CareFirst BlueChoice, Inc.

www.carefirst.com/pshbp

Customer Service 833-489-1316

2025

A Health Maintenance Organization (Blue Value Plus Option) and a High Deductible Health Plan (HDHP)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details. This plan is accredited. See page 14.

Serving: Maryland, the Northern Virginia area and Washington, DC

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements. Only Postal Employees and Annuitants may enroll in this plan.

K4A BlueChoice Advantage HDHP - Self Only

K4C BlueChoice Advantage HDHP - Self Plus One

K4B BlueChoice Advantage HDHP - Self and Family

K4D Blue Value Plus - Self Only

K4F Blue Value Plus - Self Plus One

K4E Blue Value Plus - Self and Family

IMPORTANT

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI - 73-913

Important Notice

Important Notice for Medicare-eligible Active Employees from CareFirst BlueChoice, Inc. About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the CareFirst BlueChoice, Inc. prescription drug coverage for active employees is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D plan and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D plan, you can keep your PSHB coverage and your PSHB plan will coordinate benefits with Medicare.

Please be advised

If you lose or drop your PSHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov , or call the SSA at 800-772-1213 TTY 800-325-0778.

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your PSHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your PSHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about open market Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of **CareFirst BlueChoice, Inc.** under contract (CS 2879 PS) between **CareFirst BlueChoice, Inc.** and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits (FEHB) law, as amended by the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. Customer service may be reached at 833-489-1316 or through our website: www.carefirst.com/pshbp The address for **CareFirst BlueChoice, Inc.** administrative offices is:

Mail Administrator
P.O. Box 14114

Lexington, KY 40512-4114

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). You do not have a right to benefits that were available before January 1, 2025, under the FEHB Program unless those benefits are also shown in this PSHB Plan brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2025. Rates are shown at the end of this brochure.

Plain Language

Plain Language

All brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means **CareFirst BlueChoice, Inc.**
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium. Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the PSHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 833-489-1316 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go towww.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain family members on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain PSHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.

- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.

- https://psnet.ahrq.gov/issue/national-patient-safety-foundation The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions (“Never Events”)

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.” We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your PSHB plan will incur costs to correct the medical error.

PSHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
• **Minimum essential coverage (MEC)**	Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
• **Minimum value standard**	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
• **Where you can get information about enrolling in the PSHB Program**	See https://health-benefits.opm.gov/PSHB/ or enrollment information as well as: • Information on the PSHB Program and plans available to you • A health plan comparison tool Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System. Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your PSHB coverage. These materials tell you: • When you may change your enrollment • How you can cover your family members • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire • What happens when your enrollment ends • When the next Open Season for enrollment begins We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office. Once enrolled in your PSHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.
• **Enrollment types available for you and your family**	Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov/PSHB/ For assistance with the PSHB System, call the PSHBP Helpline at (844) 451-1261. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment request. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please, report changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one PSHB plan, you or they cannot beenrolled in or covered as a family member by another enrollee in another PSHB or FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the PSHB Program, change your enrollment, or cancel coverage using the PSHB System. For a complete list of QLEs, visit the PSHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member, as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the PSHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no PSHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the PSHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for PSHB coverage, you must continue your PSHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)

Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please, contact CMS for assistance (800) 633-4227.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the PSHB Program. Generally, you must have been enrolled in the FEHB and/or PSHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When PSHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

- **Upon divorce**

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are not eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB plan in the interim).

- **Medicare PDP EGWP**

  When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at (833) 489-1316.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your PSHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn 26.

  You may not elect TCC if you are fired from your Federal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance . It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing PSHB Program coverage.

- **Converting to individual coverage**

  You may convert to a non-PSHB individual policy if:

  - Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
  - You decided not to receive coverage under TCC or the spouse equity law; or
  - You are not eligible for coverage under TCC or the spouse equity law.

  If you leave Federal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

  Your benefits and rates will differ from those under the PSHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 833-489-1316 or visit our website at www.carefirst.com/pshbp

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that PSHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. CareFirst BlueChoice, Inc. holds the following accreditation: NCQA accreditation. To learn more about this plan's accreditation(s), please visit the following websites: National Committee for Quality Assurance (www.ncqa.org). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a Blue Value Plus Plan or a High Deductible Health Plan (HDHP).

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our Blue Value Plus Plan

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

General features of our BlueChoice Advantage High Deductible Health Plan (HDHP)

Our HDHP is called the BlueChoice Advantage HDHP. HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of PSHB plans. PSHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

There is no medical deductible for the Blue Value Plus Option. There is a $100 deductible for Self Only enrollment and $200 Self Plus One and Self and Family enrollment that applies to all prescription drugs except for Tier 1 preferred generics under the Blue Value Plus option. Under the BlueChoice Advantage HDHP Option, there is a $1,650 Self Only enrollment deductible and $3,300 Self Plus One and Self and Family enrollment deductible in-network and there is a $3,300 Self Only enrollment deductible and $6,600 Self Plus One and Self and Family enrollment deductible out-of-network. Only CareFirst allowable charges are applicable to the deductible. The annual deductible must be met before Plan benefits are paid for care other than preventive care.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, excluding specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA (except for veterans with a service-connected disability) or Indian Health Service (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual in-network out-of-pocket expenses for covered services, including deductibles, coinsurance and copayments, to no more than $7,050 for Self Only enrollment, and $14,100 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit but cannot exceed that amount. See page 78 or 154 if you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). Our plan specific out-of-pocket limits are as follows:

- For the Blue Value Plus Option, the catastrophic limit is $6,500 per Self Only enrollment and $13,000 per Self Plus One and Self and Family enrollment for in-network services.
- For the BlueChoice Advantage HDHP, the catastrophic limit is $5,500 per Self Only enrollment and $11,000 per Self Plus One and Self and Family enrollment for in-network services. For out-of-network services, the catastrophic limit is $7,500 per Self Only enrollment and $15,000 per Self Plus One and Self and Family enrollment.

Out-Of-Pocket Maximum

- **Individual Coverage:**
  - The member must meet the individual out-of-pocket maximum.
- **Family Coverage:**
  - Each Member can satisfy their own individual out-of-pocket maximum by meeting the individual out-of-pocket maximum. In addition, eligible expenses of all covered family members can be combined to satisfy the family out-of-pocket maximum.
  - An individual family member cannot contribute more than the individual out-of-pocket maximum toward meeting the family out-of-pocket Maximum
- Once the family out-of-pocket maximum has been met, this will satisfy the out-of-pocket maximum for all family members.

These amounts apply to the out-of-pocket maximum:
- Co-payments and coinsurance for all covered services.
- Prescription drug benefit Rider co-payments and coinsurance for all covered services.
- Deductible

- Note: When the member has reached the out-of-pocket maximum, no further co-payments, coinsurance or deductible will be required in that benefit period for covered services. The in-network and out-of-network out-of-pocket maximum contributes towards one another.

Health education resources and account management tools

We make available a wide variety of self-service tools and resources to help you take personal control of your health. Below is a list of some of these tools and resources, many of which are available through our website at www.carefirst.com/pshbp.

- Health education resources — preventive guidelines, patient safety tips, wellness and disease information, prescription drug interaction and pricing tools, and newsletters
- Account management tools — online claims payment history and HSA or HRA balance information
- Treatment Cost Estimator- located on MyAccount and provides consumers estimated costs for services.
- Consumer choice information — online provider directory and health services pricing tool
- Care support information — case management programs
  For more information about these and other available tools and resources, please see the HDHP Section.

Your rights and responsibilities

OPM requires that all PSHB plans provide certain information to their PSHB members. You may get information about us, our networks, and our providers. OPM's PSHB website www.opm.gov/healthcare-insurance/ lists the specific types of information that we must make available to you.

Some of the required information is listed below:

- We are in compliance with Federal and State licensing and certification requirements
- We have been in existence since 1984
- We are a non-profit corporation
- CareFirst BlueChoice, Inc. is an independent licensee of the BlueCross and BlueShield Association, a registered trademark of the BlueCross and BlueShield Association and a registered trademark of CareFirst of Maryland, Inc.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, CareFirst BlueChoice, Inc. at www.carefirst.com/pshbp. You can also contact us to request that we mail a copy to you.

If you want more information about us, call (883)-489-1316, or write to Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114. You may also visit our website at www.carefirst.com/pshbp.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.carefirst.com/pshbp to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies. In addition, we may use or disclose your information for health benefits administration purposes (such as claims and enrollment processing, care management and wellness offerings, claims payment and fraud detection and prevention efforts), and our business operations (including for quality measurement and enhancement and benefit improvement and development. You may view our Notice of Privacy Practice for more information about how we use and disclose member information by visiting our website at www.carefirst.com/pshbp.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is: The District of Columbia; the state of Maryland; in Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the area of Fairfax and Prince William Counties in Virginia lying east of route 123.

Under the BlueChoice Advantage HDHP, if you elect to receive care outside of our service area, the care will be treated as out-of-network with the exception of emergency care.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live outside of the service area (for example, if your child goes to college in another state), you may be able to take advantage of our Guest Membership Program. This program will allow you or your dependents, which reside outside of the service area for an extended period of time, to utilize the benefits of an affiliated Blue Cross and Blue Shield HMO. Please contact us toll free at (833)-489-1316 for more information on the Guest Membership Program. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. New for 2025

This is the first year for the Postal Service Health Benefits Program (PSHBP). This Section is not an official statement of benefits. For that, go to Section 5. Benefits.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the PSHB System enrollment confirmation.

Note: If you are enrolled in our Medicare Part D PDP EGWP, you will receive a second ID card for your prescription drug benefits.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (833)-489-1316 or write to us at Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114. You may also request replacement cards through our website: www.carefirst.com/pshbp

Where you get covered care

You get care from "Plan providers" and "Plan facilities". You will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies) if you use BlueChoice providers under both the Blue Value Plus and BlueChoice option. If you use the point-of-service feature under BlueChoice, you can also get care from providers in other CareFirst networks as well as non-participating providers. Under BlueChoice, this will cost you more than using our BlueChoice network. Under both Blue Value Plus and BlueChoice, you are not required to obtain a referral from your primary care provider or another participating physician in our network. You are still responsible for choosing a primary care provider and returning the Selection Form to us or notifying Member Services at (833)-489-1316 of your selection.

Balance Billing Protection

PSHB Carriers must have clauses in their in-network (participating) provider agreements.? These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount.? If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state’s designation as a medically underserved area.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at (833)-489-1316 or www.carefirst.com/pshbp for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your health care. Each member may choose their primary care provider from our provider directory available on our website, www.carefirst.com/pshbp.

- **Primary care**

Your primary care provider can be a family practitioner, general practitioner, internist, or pediatrician. Your primary care provider will provide or coordinate most of your healthcare.
If you want to change primary care providers or if your primary care provider leaves the plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care provider may refer you to a specialist for needed care or you may go directly to a specialist without a referral. Under BlueChoice, you may use other providers, but out-of-network coverage levels will apply.

Here are some other things you should know about specialty care:

- Your primary care provider will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. While BlueChoice provides out-of-network benefits with higher out-of-pocket, our Open Access plan generally will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another in-network specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else. Under BlueChoice, you may continue to see your current specialist, or see any out-of-network specialist, but your care would be paid at the out-of-network level.
- If you have a chronic and disabling condition and
  - lose access to your specialist because your coverage changed from the FEHB to the PSHB and your health plan does not participate in the PSHB; or
  - lose access to your specialist because we drop out of the Postal Service Employees Health Benefits (PSHB) Program and you enroll in another PSHB program plan; or:
  - lose access to your specialist because we terminate our contract with your specialist for other than cause; or
  - lose access to your specialist because we reduce our service area and you enroll in another PSHB plan; you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (833)-489-1316. If you are new to the PSHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to this PSHB plan, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the PSHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care provider arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care provider has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior approval for:

- Dialysis in a hospital setting
- Growth hormone therapy (GHT)
- Home health care
- Hospice care
- Outpatient services
- Non-routine maternity admission rendered outside of the CareFirst Service Area and/ or by out-of- network non-participating providers require precertification under BlueChoice
- Skilled nursing facility
- Specialty drugs
- Organ and Tissue Transplants
- Genetic Testing
- Sleep Studies (except non-attended)
- Air Ambulance Services
- Specialized Radiation Therapy
- Artificial Insemination Infertility Treatments and fertility drugs
- Habilitative and Applied Behavioral Analysis (ABA)
- Inpatient and outpatient hospital Electroconvulsive Therapy (ECT)
- Inpatient and outpatient hospital Repetitive Transcranial Magnetic Stimulation (TMS)
- Inpatient Behavioral Health and Substance Use Disorder
- Residential Treatment Centers (RTC)
- See www.provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page for a list of specific Covered Services which require prior authorization

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at (866) 773-2884 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility: and
- number of days requested for hospital stay.

Blue Value Plus Plan:
Prior authorization is required for all In-Network outpatient services performed in the outpatient department of a hospital, including but not limited to, outpatient surgery, specialty imaging, diagnostic, laboratory and X-ray services, Outpatient Rehabilitative Services and Infusion Services.
Benefits will not be approved at these locations if CareFirst BlueChoice determines that the procedure can be provided in a medically appropriate manner within a physician's office or other less intensive and less costly setting.
If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are not covered. Prior authorization for in-network services is the responsibility of the in-network provider and a member cannot be held liable when an in-network provider fails to obtain prior authorization.

BlueChoice Advantage Plan:

Prior authorization from CareFirst BlueChoice will be obtained by in-network providers and out-of-network participating providers located in the CareFirst BlueChoice Service Area. If these providers fail to obtain prior authorization, the Member shall be held harmless. Except for Urgent Care, Emergency Services and follow-up care after emergency surgery, it is the Member's responsibility to obtain prior authorization for (1) Medical Devices and Supplies for In-Network Covered Services, (2) when services are rendered outside of the CareFirst BlueChoice Service Area and (3) for services rendered by out-of-network non-participating providers.

Failure of the Member to meet the utilization management requirements or to obtain prior authorization for services listed in (1), (2) or (3) above, may result in a reduction or denial of the Member's benefits even if the services are Medically Necessary. Refer to the Schedule of Benefits to determine the Utilization Management Non-Compliance penalty.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

  If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

  We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (833)-489-1316. You may also call OPM's Postal Service Insurance Operations (PSIO) at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (833)-489-1316. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

  You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

  Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Under our BlueChoice option, certain services can be obtained from out-of-network providers. For services requiring prior authorization or pre-certification, refer to the "You need prior Plan approval for certain services" section.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call (888) 789-9065.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
3. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See Section. 8(a) for information about the PDP EGWP appeal process.

Section 4. Your Cost for Covered Services

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care provider, under Blue Value Plus option, you pay a copayment of $15 per office visit, and when you go to an outpatient hospital for surgery, you pay a facility copayment of $200.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. The Blue Value Plus Option has no medical deductible. There is a $100 deductible for Self and $200 for Self Plus One and Self and Family for Tier 2-5 prescription drugs under the Blue Value Plus Option. The BlueChoice Advantage HDHP has a deductible of $1,650 for Self Only enrollment or $3,300 for Self Plus One and Self and Family enrollment for in-network services and $3,300 for Self Only enrollment and $6,600 for Self Plus One and Self and Family enrollment for out-of-network care each calendar year. Individual Coverage: The member must satisfy the individual deductible. Self Plus One and family coverage: The deductible may be met entirely by one member or by combining eligible expenses of two or more covered family members. There is no individual deductible with family coverage. The family deductible must be reached before CareFirst pays benefits for covered services subject to the deductible for any member who has family coverage. The deductible applies to all benefits excluding all preventive services. Only CareFirst allowable charges are applicable to the deductible. Under the Self Only, Self Plus One, and Self and Family enrollments, services for any or all members contribute to the deductible. Those services subject to the deductible are indicated in Sections 5(a) through 5(g). Note: If you change plans during Open Season, the effective date of your new PSHB plan is January 1 of the next year, and a new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan. If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: In our Plan, you pay 25% of our allowance for durable medical equipment
Differences between our Plan allowance and the bill	Our "allowed benefit" is the amount we use to calculate our payment for certain types of covered services. Plans arrive at their allowances in different ways, so they may vary. For information on how we determine our allowed benefit, see the definition of allowed benefit in Section 10.

Often, the provider's bill is more than our allowed benefit. It is possible for a provider's bill to exceed the allowance by a significant amount. Whether or not you have to pay the difference will depend on the type of provider you use. BlueChoice has a network of providers who will always accept our allowed benefit. Under our BlueChoice Advantage HDHP option, there are other providers contracted with CareFirst who will only bill you for the amount attributed to the deductible or the appropriate copayment or coinsurance. Please check the Hearing Aid benefit in Section 5(a) for detail for when network providers may bill for balances.

Under BlueChoice, non-participating providers who provide out-of-network services will bill you for any balances in excess of our allowance for covered services in addition to the appropriate deductible, copayment or coinsurance amount.
You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

Under Blue Value Plus, once your expenses for in-network care (coinsurance, co-payments and deductible) total $6,500 for Self Only enrollment or $13,000 for Self Plus One and Self and Family enrollment in any calendar year you do not have to pay anymore for covered services. All covered in-network care counts toward the catastrophic limit. Only expenses up to our allowed benefit contribute; any balances in excess of our allowed benefit does not contribute to the catastrophic limit and remain your liability. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Under the BlueChoice Advantage HDHP option, once your expenses for in-network services are met (coinsurance, copayments and deductible) totaling $5,500 for Self Only enrollment or $11,000 for Self Plus One and Self and Family enrollment in any calendar year), you do not have to pay any more for covered in-network services. All covered in-network care counts toward the catastrophic limit. The catastrophic limit for out-of network care is $7,500 for Self Only enrollment and $15,000 for Self Plus One and Self and Family enrollment in any calendar year, and only expenses up to our allowed benefit contribute; any balances in excess of our allowed benefit does not contribute to the catastrophic limit and remain your liability.

Please note that the out-of-pocket maximums will be combined for both in-network and out-of-network services for the HDHP BlueChoice Advantage option.
Out-Of-Pocket Maximum

- Individual Coverage:
  - The member must meet the individual out-of-pocket maximum.
- Family Coverage:
  - Each member can satisfy their own individual out-of-pocket maximum by meeting the individual out-of-pocket maximum. In addition, eligible expenses of all covered family members can be combined to satisfy the Self and Family out-of-pocket maximum.
  - An individual family member cannot contribute more than the individual out-of-pocket maximum toward meeting the Self and Family out-of-pocket maximum
  - Once the Self and Family out-of-pocket maximum has been met, this will satisfy the out-of-pocket maximum for all family members.

These amounts apply to the out-of-pocket maximum:

- Co-payments and coinsurance for all covered services
- Prescription drug benefit Rider co-payments and coinsurance for all covered services
- Deductible

Note: When the member has reached the out-of-pocket maximum, no further co-payments, coinsurance or deductible will be required in that benefit period for covered services. The in-network and out-of-network out-of-pocket maximum contributes towards one another.

For members enrolled in our Plan's associated PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s).

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all eligible covered prescription drug benefits.

Carryover

If you changed to this PSHB Plan during Open Season from a plan with a catastrophic protection benefit the effective date of the change is January 1, and covered expenses that apply to this plan's catastrophic protection benefit starts on January 1.

Note: If you change PSHB plans during Open Season the effective date of your new PSHB plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.carefirst.com/pshbp or contact the health plan at (833) 489-1316.

Section 5. Blue Value Plus Option Benefits

Page 192 is a benefit summary of the option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. Blue Value Plus Option Benefits Overview

This Plan offers a Blue Value Plus Option. The Blue Value Plus Option benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

The Blue Value Plus Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 833-489-1316 or on our website at www.carefirst.com/pshbp.

Blue Value Plus Option

Blue Value Plus Plan does not require referrals to see a specialist
•Preventive care and Women's health services are covered with no copay
•$15 PCP copay and $50 specialist copay
•$30 copay for lab and $50 copay x-ray at preferred network providers
•25% coinsurance per admission copay for inpatient hospitalization
•$150 facility copay for surgery in an Ambulatory Surgical Center and $200 facility fee for outpatient hospital
•Prescriptions: - There is a $100 deductible for Tiers 2 through Tiers 4 for Self and $200 for Self Plus One and Self & Family

For up to a 34-day supply:
$10 copay for Tier-1 preferred generic drug

$50 for Tier-2 preferred brand name drug

$100 for Tier-3 -preferred specialty generic drug

$150 for Tier-4 preferred specialty brand name drug

For a 35-day through 90-day supply: two (2) copays

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The member is responsible for any applicable copayment or coinsurance listed in this schedule.
- Blue Value Plus has no medical deductible. There is a $100 deductible for Self Only enrollment and $200 deductible for Self Plus One and Self and Family enrollment for Pharmacy Tiers 2 - Tiers 4.
- When the allowed benefit for any covered service is less than the copayment listed, the member payment will be the allowed benefit.
- Prior authorization is required for all outpatient services performed in the outpatient department of a hospital.
- If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are considered as a non-covered service.
- Prior authorization is not required for clinic visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.
- When multiple services are rendered on the same day by more than one provider, member payments are required for each provider.
- Be sure to read Section 4, Your Costs for Covered Services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate co-pays and coinsurances.

Benefit Description	You pay
Professional Services	**Blue Value Plus**
Professional services of physicians • In physician's office • Inpatient/Skilled nursing Professional (Non-Surgical) • Outpatient Professional (Non-Surgical) • Office medical consultations • Second surgical opinion	Office/Outpatient Hospital In-network: • PCP - $15 copay • Specialist - $50 copay Note: Office visits rendered in a hospital, hospital clinic or health care provider’s office visit on a hospital campus are not subject to the facility copay. Inpatient Hospital/Skilled Nursing In-network: • 25% of plan allowance
Convenience Care (Retail Health Clinic)	In-network: • $15 copay

Professional Services - continued on next page

Benefit Description	You pay
Professional Services (cont.)	**Blue Value Plus**
While primary care providers should be the first line of defense for members, there are tiered care alternatives members can access when their PCP is not available such as CVS MinuteClinic, Walgreens TakeCare and Target Clinic who can serve as the immediate backup to PCPs. (after hours)	In-network: • $15 copay
Telehealth services	**Blue Value Plus**
Telemedicine Services: Telemedicine refers to the use of a combination of interactive audio, video, or other electronic media used by a licensed health care provider for the purpose of diagnosis, consultation, or treatment consistent with the provider's scope of practice. Note: Telemedicine must have a video and audio component. Telephone consultations are not a covered service.	Benefits are available to the same extent as benefits provided for other services. Example: - If services are rendered by a PCP, the member would be responsible for the PCP cost- share. -If services are rendered by a Specialist, the member would be responsible for the Specialist cost-share.
CloseKnit, provides virtual only primary care services through a dedicated care team of physicians, nurse practitioners, physician assistants, licensed professional counselors and licensed clinical social workers • Well care / Annual Wellness • Preventative care • Urgent Care • Lifestyle support • Chronic condition prevention and management • Medication management • Clinical educational support • Behavioral Health and mental health support through professional counselors • Care Coordination, including ongoing assistance with care activities such as arranging appointments with specialists, refiling prescriptions, etc.	In-network: • No copay
Diagnostic Services (Professional)	**Blue Value Plus**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG	Office/Freestanding Setting: In-Network • Labs - $30 copay • X-rays - $50 copay • Other Diagnostic Services - $50 copay

Diagnostic Services (Professional) - continued on next page

Benefit Description	You pay
Diagnostic Services (Professional) (cont.)	**Blue Value Plus**
Specialty Imaging: • MRA/MRS • MRI • PET • CT/CAT scans	**In-Network:** $100 copay
Preventive care, adult	**Blue Value Plus**
Routine physicals allowed once per benefit period including screenings. The **following** preventive services are covered at the time interval recommended at each of the links below: • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Genetic Testing: Prior Authorization is required for genetic testing. Ordering providers must obtain authorization for all genetic tests either by accessing the CareFirst provider portal under Pre-Auth/Notifications or calling AIM directly at (844) 377-1277. HLA Typing/Preimplantation (related to in vitro fertilization) may require authorization through the health plan and can be managed in CareFirst's provider portal under Medical Prior Authorization and no authorization is required for Cologuard®.	In-network: • No copay
• Routine mammogram	In-network: • No copay

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Blue Value Plus**
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules/ Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: • No copay
Routine Prostate Specific Antigen (PSA) test - one (1) annually for men age 40 and older in accordance with the most current American Cancer Society guidelines.	In-network: • No copay
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities. • Intensive nutrition and behavioral weight-loss counseling therapy, • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Note: • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) or 5(f)(a) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See section 5(b) for Surgery requirements and cost share. • Also see Section 5(h) for additional programs that offer nutritional and physical activity support.	In-network: • No copay
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.*	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Blue Value Plus**
• *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**Blue Value Plus**
Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to www.brightfutures.aap.org Children's immunization's endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html	In-network: • No copay
You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: • No copay
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Note: • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See section 5(b) for Surgery requirements and cost share.	In-network: • No copay

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**Blue Value Plus**
• Also see Section 5(h) for additional programs that offer nutritional and physical activity support.	In-network: • No copay
Maternity care	**Blue Value Plus**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression Note: Members are responsible for both physician and facility fees. Please refer to section 5C for outpatient or inpatient facility fees. • Preventive Services: - Preventive outpatient obstetrical care of an uncomplicated pregnancy, including prenatal evaluation and management office visits and one postpartum office visit; - Prenatal laboratory tests and diagnostic services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration; - Preventive laboratory tests and services rendered to a newborn during a covered hospitalization for delivery, identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B," the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, including the collection of adequate samples for hereditary and metabolic newborn screening and newborn hearing screening; and • Non-Preventive Services: - Outpatient obstetrical care and professional services for all prenatal and post-partum complications, including prenatal and post-partum office visits and ancillary services provided during those visits.	In-network: • Preventive- No charge • Non-Preventive- $50 • Professional Services at Delivery - 25% of plan allowance

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**Blue Value Plus**
- Birthing classes, one course per pregnancy, at a CareFirst BlueChoice approved facility; Note: Members enrolled in the High-Risk OB Care Management Program may be eligible to receive a home blood pressure cuff. • Professional Services at Delivery - Professional services are covered under Section 5(a).	In-network: • Preventive- No charge • Non-Preventive- $50 • Professional Services at Delivery - 25% of plan allowance
Breastfeeding and lactation support, supplies and counseling for each birth. Note: Benefit coverage for breastfeeding support, supplies and counseling for each birth begin immediately after delivery. Breastfeeding support benefits include but are not limited to the following: comprehensive lactation support, lactation counseling, and supplies in conjunction with each birth. These benefits begin immediately following delivery. Breast pumps are available one per calendar year pre- or post-natal. Here are some things to keep in mind: • You do not need to pre-certify your vaginal delivery; see page 23for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).	In-network: • Preventive- No charge • Non-Preventive- $50 • Professional Services at Delivery - 25% of plan allowance

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**Blue Value Plus**
Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	In-network: • Preventive- No charge • Non-Preventive- $50 • Professional Services at Delivery - 25% of plan allowance
Not covered: • *Doulas* • *Surrogacy*	*All charges*
Family planning	**Blue Value Plus**
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms • Contraceptive counseling on an annual basis at no cost sharing. Note: See additional Family Planning and Prescription drug coverage Section 5(f) or 5(f)(a). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. Your provider can request authorization by following the steps outlined at www.provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page. Urgent requests will be reviewed within 24 hours. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	In-network: • No copay
Voluntary male sterilization	In-network:

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**Blue Value Plus**
Hospital services are covered under Sect. 5(c) Surgical benefits are covered under Sect. 5(b)	In-network: • No copay
FDA Approved Fertility Apps	In-network: • No copay
Not covered: • Reversal of voluntary surgical sterilization • Genetic counseling • Fertility drugs that are not deemed medically necessary • Elective Abortion	*All charges*
Infertility services	**Blue Value Plus**
Diagnosis and treatment of infertility specific to: • Artificial insemination: - Intravaginal Insemination (IVI) - Intracervical Insemination (ICI) - Intrauterine Insemination (IUI) • Fertility drugs see Section 5(f) or 5(f)(a) Note: • We cover drugs for the treatment of infertility, when deemed medically necessary. • When covered for artificial insemination, injectable drugs are medical benefits, and oral drugs are benefits under prescription drug coverage. See Section 5(f). • Prior authorization for the treatment must be obtained from CareFirst BlueChoice. • Benefits are limited to three (3) attempts per benefit period. • Any charges associated with the collection of the sperm will not be covered unless the partner is also a member. • The member is responsible for the copayment or coinsurance for artificial insemination stated in the Schedule of Benefits. • Coverage is subject to the General Exclusions in Section 6 and the Not Covered section at the end of this Description of Services. • Procedure is covered regardless of whether the couple has a relationship under which the PSHB Program recognizes each partner as a spouse of the other.	In-network: • 50% coinsurance

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**Blue Value Plus**
• Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees. • Infertility is the inability to conceive or produce conception after 1 year of unprotected sex when an individual is under 35 years of age, or 6 months for an individual age 35 or older or failed attempts at artificial insemination. There are various reproductive treatments available for people facing infertility, which are customized according to their medical history and diagnostic results.	In-network: • 50% coinsurance
In vitro fertilization (IVF) IVF involves stimulation of the ovaries with exogenous hormones, retrieval of oocytes/ova (eggs), fertilization of the oocytes in a petri dish, and the transfer of any resulting embryo(s) back into the uterus. Note: • Benefits are limited to three attempts per live birth and limited to $45,000 payment per plan year • Prior authorization for the treatment must be obtained from CareFirst BlueChoice. • IVF benefits are considered if the patient has been unable to attain a successful pregnancy through a less costly infertility treatment under the policy • Infertility is the inability to conceive or produce conception after 1 year of unprotected sex when an individual is under 35 years of age, or 6 months for an individual age 35 or older or failed attempts at artificial insemination. There are various reproductive treatments available for people facing infertility, which are customized according to their medical history and diagnostic results. • See Section 5(f) or 5(f)(a) for In vitro fertilization (IVF) drugs • Procedure is covered regardless of whether the couple has a relationship under which the PSHB Program recognizes each partner as a spouse of the other. • The in vitro fertilization procedures must be performed at medical facility that conforms to the American College of Obstetricians and Gynecologists (ACOG) guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine (ASRM), (formerly the American Fertility Society) minimal standards for programs of in vitro fertilization.	In-network: • 50% coinsurance

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**Blue Value Plus**
• A completed *Assisted Reproductive Technology Pre-Treatment Form* is required to be submitted for approval, by the Physician. This form may be obtained on the CareFirst website at www.carefirst.com/providers. • Once services are approved, providers will need to obtain separate authorization for infertility medication.	In-network: • 50% coinsurance
Iatrogenic infertility Standard Fertility Preservation for members who have been diagnosed with Iatrogenic Infertility: • the collection of sperm • cryopreservation of sperm • collection of embryo • cryopreservation of embryo • collection of oocyte • cryopreservation of oocyte • benefits limited to up to 12 months of storage of sperm, oocytes and embryo • Fertility drugs see Section 5(f) or 5(f)(a) Prior authorization for the treatment must be obtained from CareFirst BlueChoice. Benefits are limited to three (3) attempts per live birth. If a live birth occurs within the 3 attempts the benefit renews. If the member has 3 failed attempts, the benefit is exhausted for the lifetime of the coverage even if the member switches plans the exhausted benefit does not renew.	In-network: • 50% coinsurance Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees
Not covered: • *Embryo transfer and gamete intra-fallopian transfer (GIFT),* • *Zygote intra-fallopian transfer (ZIFT)* • *Intrauterine and Assisted reproductive technology (ART) procedures, such as:* - *Services and supplies related to ART procedures* - *Cost of donor sperm* - *Cost of donor egg* - *Drugs for non-covered procedure*	*All charges*

Benefit Description	You pay
Allergy care	**Blue Value Plus**
• Testing and treatment • Allergy injections	In-network: • PCP - $15 copay • Specialist - $50 copay
Allergy serum	In-network: • PCP - $15 copay • Specialist - $50 copay
Not covered: *Provocative food testing and Sublingual allergy desensitization*	*All charges*
Treatment therapies	**Blue Value Plus**
• Radiation therapy • Respiratory and inhalation therapy • Dialysis - hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 21 For Chemotherapy and Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy see Infusion Services under Section 5 (a) For services rendered by Home Health provider see Home Health benefits	**In-network:** • PCP - $15 copay • Specialist - $50 copay
Infusion Services	**Blue Value Plus**
Infusion Services means treatment provided by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion Services also includes enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. Infusion Services includes all medications administered intravenously and/or parenterally.	**In network:** • Home/Office/Freestanding - $20 copay • Outpatient Hospital - $200 copay

Infusion Services - continued on next page

Benefit Description	You pay
Infusion Services (cont.)	**Blue Value Plus**
Infusion Services: Prior Authorization required for Specialty Drugs • Transfusion services and Infusion Services, including - home infusions, - infusion of therapeutic agents, - medication and nutrients, - enteral nutrition into the gastrointestinal tract, - chemotherapy, and - prescription medications. - Blood and Blood Products (including derivatives and components) that are not replaced by or on behalf of the member Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants.	**In network:** • Home/Office/Freestanding - $20 copay • Outpatient Hospital - $200 copay
Physical, Occupational and Speech therapies	**Blue Value Plus**
Up to 60 visits (combined physical, occupational and/or speech therapy) per condition per benefit period for the services of the following qualified providers: • Physical therapists • Occupational therapists • Speech therapists Note: Coverage shall include Physical Therapy, Occupational Therapy and Speech Therapy for the treatment of individuals who have sustained an illness or injury that CareFirst BlueChoice determines to be subject to improvement Note: We only cover therapy when a physician: • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed. Note: Occupational Therapy is limited to the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual. Brochure language also states under member liability:	In-network: • $50 office copay

Physical, Occupational and Speech therapies - continued on next page

Benefit Description	You pay
Physical, Occupational and Speech therapies (cont.)	**Blue Value Plus**
• Other than any applicable inpatient or outpatient facility copay, member has no copay or coinsurance during an approved inpatient stay. See Section 5 (c) for information on outpatient facility services.	In-network: • $50 office copay
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Maintenance therapys*	*All charges*
Habilitative therapy	**Blue Value Plus**
• Habilitative Services are services, including Occupational Therapy, Physical Therapy, and Speech Therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. • Benefits are subject to the applicable Occupational Therapy, Physical Therapy, and Speech Therapy copay but are not counted toward any visit maximum for therapy services. • Habilitative Therapy ABA coverage for Applied Behavioral Analysis include Verbal Behavior therapy, Occupation Therapy, Physical Therapy and Speech Therapy from 18 months to 21 years of age. There will be no visit maximums and preauthorization will be required. • Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient facility fees.	**In-network:** • $50 office copay
Not Covered: Benefits for Habilitative Services delivered through early intervention or school services.	*All charges*
Cardiac Rehabilitation	**Blue Value Plus**
Up to 90 visits per condition per benefit period Note: Cardiac Rehabilitation benefits are provided to Members who: • have been diagnosed with significant cardiac disease • suffered a myocardial infarction • undergone invasive cardiac treatment immediately preceding referral Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees	**In-network:** • $50 office copay

Cardiac Rehabilitation - continued on next page

Benefit Description	You pay
Cardiac Rehabilitation (cont.)	**Blue Value Plus**
Not covered *Benefits are not provided for maintenance cardiac rehabilitation*	*All charges*
Pulmonary Rehabilitation	**Blue Value Plus**
Pulmonary Rehabilitation • For those who have significant pulmonary disease or who have undergone certain surgical procedures of the lung. • Limited to one (1) pulmonary rehabilitation program per lifetime. • *Benefits are not provided for maintenance programs* Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.	**In-network:** • $50 office copay
Hearing services (testing, treatment, and supplies)	**Blue Value Plus**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children*.	**In-network:** • $50 office copay
• Hearing Aids Note: Medical devices, such as bone anchored hearing aids (BAHA) and cochlear implants, (that or which) are surgically implanted see Orthopedic and Prosthetic Supplies. For additional **details, see page 47 under the Orthopedic and prosthetic supplies.** - *Medically necessary external hearing aid is covered up to our plan allowance every 36 mont*hs.	In-network: • 25% of the plan allowance Limited to $2,000 payment per 36 months
Not covered: *Hearing services that are not shown as covered*	*All charges*

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	**Blue Value Plus**
• Medical Vision Services Note: This is a medical benefit not a vision benefit - One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) - Annual eye refractions - Medical eye exams	**In-network:** • $50 office copay
Routine eye exams Note: See Preventive care, children for eye exams for children Note: Eye care and exams related to medical conditions are subject to the specialist copay	**In-network**: • $10 per visit at Davis Vision Providers
Not covered: • *Eyeglasses or contact lenses (except as listed above)* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses except as provided by Davis Vision.* • *Deluxe eyeglass frames or lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.* • *Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom* • Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of medical conditions as outlined in the CareFirst Medical Policy. • *LASIK, INTACS, radial keratotomy, and other refractive surgical services* • *Refractions, including those performed during an eye examination related to a specific medical condition*	*All charges*

Benefit Description	You pay
Foot care	**Blue Value Plus**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts	**In-network:** • PCP - $15 copay • Specialist - $50 copay Note: Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees.
Not covered: • *Other routine palliative or cosmetic care of the feet including flat foot conditions, supportive devices for the foot, treatment of sublaxations 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.*	*All charges*
Orthopedic and prosthetic devices	**Blue Value Plus**
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Hair Prosthesis (wig) is covered when prescribed by a treating oncologist and the hair loss is the result of chemotherapy. The Plan will cover up to $350 for one (1) hair prosthesis per benefit period. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. • Internal prosthetic devices such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Medically Necessary molded foot orthotics • Notes: For information on the professional charges for the surgery to insert an implant. See Section 5 (b) Surgical procedures. For information on the hospital and or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance service.	In-Network: • 25% of plan allowance per device
Not covered: • *Orthopedic and corrective shoes* • *Arch supports, heel pads, and heel cups (except as listed under Orthopedic and prosthetic devices)* • *Over the counter orthotics* • *Lumbosacral supports*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**Blue Value Plus**
• *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Wigs, including cranial prostheses, unless otherwise specified* • *Prosthetic replacements provided less than three (3) years after the last one we covered* • *Prosthetic devices such as artificial limbs and lenses following cataract removal unless covered under the DME benefit (see Durable Medical Equipment below)*	*All charges*
Durable medical equipment (DME)	**Blue Value Plus**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Canes • Diabetic shoes • Commodes • Glucometers • Suction machines • Medical supplies (i.e. ostomy and catheter supplies, dialysis supplies, medical foods for inherited metabolic diseases and Inborn Errors of Metabolism (IEM) • Externally worn non-surgical durable devices which replace a body part or assist a patient in performing a bodily function (unless otherwise described in the "orthopedic and prosthetic devices" section above) • Externally worn braces which improve the function of a limb • Medically Necessary fitted compression stockings	**In-Network:** 25% of plan allowance up to allowed benefit Diabetic Supplies- 25% of plan allowance up to $100 for a 30-day supply

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**Blue Value Plus**
Note: Prior authorization is required for certain in-network DME covered services. In-network providers will obtain prior authorization on behalf of the member. *See https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page for a list of specific Covered Services which require prior authorization.*	**In-Network:** 25% of plan allowance up to allowed benefit Diabetic Supplies- 25% of plan allowance up to $100 for a 30-day supply
Not covered: • *Eye glasses and contact lenses (except as listed under Vision Services)* • *Dental prosthetics (except as listed under Orthopedic and Prosthetics above)* • *Foot orthotics (except as listed under Orthopedic and Prosthetics above)* • *Environment control products* • *Over the counter compression stockings* • *Medical equipment of an expendable nature (i.e. ace bandages, incontinent pads)* • *Replacement of DME equipment not due to normal wear and tear* • *Comfort and convenience items* • *Over the counter items, except as listed above* • *Exercise equipment* • *Equipment that can be used for non-medical purposes*	All charges
Home health services	**Blue Value Plus**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy. • Home health care-Postpartum visits limited to two (2) per plan year. • Home health care-Post Mastectomy/Testicle Removal visits limited to four (4) per plan year.	**In-Network:** • No Charge
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Private duty nursing*	*All charges*

Benefit Description	You pay
Chiropractic	**Blue Value Plus**
Chiropractic services, limited to spinal manipulation, evaluation, and treatment up to a maximum of 20 visits per benefit period when provided by a Plan chiropractor.	**In-Network:** • $50 office copay Note: Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees
Not covered: *Services other than for musculoskeletal conditions of the spine.*	*All charges*
Alternative treatments	**Blue Value Plus**
Acupuncture-by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner Limited to 20 visits per Benefit Period.	**In-Network:** • $50 office copay
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*
Educational classes and programs	**Blue Value Plus**
Coverage is provided for: • Diabetes self-management (sponsored by the Plan's Health Education Department) • Tobacco and nicotine cessation programs, including individual, group, phone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to quit nicotine dependence. Coverage for counseling for up to two quit attempts per year. (All medications will require a prescription to be covered, to include those that are available over the counter) • Prescribed medications approved by the FDA to treat tobacco dependence will be covered in full under the pharmacy benefit. • Medically necessary nutrition therapy • Medically necessary professional nutritional counseling	**In-network**: • No copay
Note: Benefits for all other types of health education classes and self-help programs that are not offered through the Plan's Health Education program are not covered	*All charges*

Benefit Description	You pay
Sleep Studies	**Blue Value Plus**
CareFirst BlueChoice has created a network of providers that have agreed to oversee this program. The main objective of this approach is diligent monitoring of sleep apnea patients to ensure compliance with their treatment and reducing any further medical complications arising from sleep disorders. CareFirst BlueChoice has also removed the prior authorizations for sleep apnea equipment such as CPAP machines.	**In-network:** • Home - No copay • Office - $50 copay • Freestanding - $50 copay • Outpatient Hospital - $200 copay

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require precertification.
- Surgical procedures may involve the services of a co-surgeon, surgical assistant or assistant-at surgery who may bill separately from the primary surgeon.
- Blue Value Plus has no medical deductible. There is a $100 deductible for Self Only enrollment and $200 deductible for Self Plus One and Self and Family enrollment for Pharmacy Tiers 2 - Tiers 4.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5 (c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- Member is responsible for any applicable co-payment or coinsurance listed in this schedule
- When the plan allowance for any covered service is less than the co-payment listed, the member payment will be the plan allowance.
- Prior authorization is required from all outpatient services performed in the outpatient department of a hospital.
- If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are considered a non-covered service.
- Prior authorization is not required for clinic visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.
- When multiple services are rendered on the same day by more than one provider, member payments are required for each provider.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate co-pays and coinsurances.

Benefit Description	You pay
Surgical procedures	**Blue Value Plus Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of severe obesity (bariatric surgery) Note: You must meet certain criteria to be eligible for bariatric surgery. Please see CareFirst's Medical Policy for the criteria www.provider.carefirst.com/providers/medical/medical-policy.page. Please contact Member Services at (888)-789-9065 for more details on bariatric surgery. • Insertion of internal prosthetic devices. See 5 (a) – *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. No additional copay is required for internal prostheses (devices). Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)*	*All charges*

Benefit Description	You pay
Reconstructive surgery	**Blue Value Plus Option**
• Gender Affirming Services We cover medically necessary care including where appropriate gender affirming surgery, hormone therapy, and psychotherapy. Transgender services include, but are not limited to, medical counseling, behavioral health services, hormonal therapy, reconstructive surgery and cosmetic surgery. Please note some cosmetic surgery may be specifically excluded. Prior authorization for transgender services is required. The provider must submit a request for services and clinical information prior to the anticipated date of service through the CareFirst BlueChoice authorization portal or by fax. The clinical information is reviewed for persistent, well-documented gender dysphoria, the capacity to make a fully informed decision and to consent for treatment, age of majority in a given state, documentation to support any significant medical or mental health concerns are reasonably well controlled, and a history of hormone therapy for certain procedures. The request is reviewed according to the member's contract, CareFirst BlueChoice's Operating Procedure for Transgender Services, and CareFirst BlueChoice's Medical Policy for Cosmetic and Reconstructive Surgery. The request is then reviewed by a Medical Director for final determination. The gender affirming surgeries that may be performed for transwomen (male to female) include but are not limited to: The gender reassignment surgeries that may be performed for transmen (female to male) include but are not limited to: - Salpingo-oophorectomy: removal of fallopian tubes and ovaries - Vaginectomy: removal of vagina - Vulvectomy: removal of vulva - Metoidioplasty: creation of micro-penis using the clitoris - Phalloplasty: creation of penis, with or without urethra - Hysterectomy: removal of uterus - Urethroplasty: creation of urethra within penis - Scrotoplasty: creation of scrotum - Testicular prosthesis: implantation of artificial testes	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**Blue Value Plus Option**
- Mastectomy: removal of the breast	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance
Not covered:	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**Blue Value Plus Option**
• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*
Oral and maxillofacial surgery	**Blue Value Plus Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. Note: See Section 5(c) for outpatient facility or inpatient hospital admission copays	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Removal of impacted teeth* • *Any other dental surgery not listed or the result of traumatic injury or treatment of cleft pallet*	*All charges*
Organ/tissue transplants	**Blue Value Plus Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the plan. Refer to Other services in Section 3 for prior authorization procedures. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. • Cornea • Heart • Heart/lung • Intestinal transplant - Isolated small intestine - Small intestine with the liver	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:**

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Blue Value Plus Option**
- Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung single/bilateral/lobar • Pancreas These **tandem blood or marrow stem cell transplants** for covered transplants are subject to medical necessity review by the Plan. Refer to *other services* in Section 3 for prior authorization procedure. • Autologous tandem transplant for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) Note: See Section 5(c) about possible outpatient facility or inpatient hospital admission copayment.	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance
Blood or marrow stem cell transplants Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL SLL) - Hemoglobinopathy - Infantile malignant osteoporosis	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Blue Value Plus Option**
- Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle Cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Childhood rhabdomyosarcoma - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Mantle Cell (Non-Hodgkin Lymphoma) - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular Mediastinal, Retroperitoneal, and ovarian germ cell tumors	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Blue Value Plus Option**
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma Note: See Section 5c about possible outpatient facility or inpatient hospital admission copayment.	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols.	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):**

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Blue Value Plus Option**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Blue Value Plus Option**
• Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient who is not covered by other insurance. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. Note: See Section 5c about possible outpatient facility or inpatient hospital admission copayment.	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay **Outpatient Hospital:** • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**Blue Value Plus Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office • Skilled Nursing	**In-network** **Office:** • PCP – $15 copay • Specialist – $50 copay **Ambulatory Surgical Center (ASC):** • PCP – $15 copay • Specialist – $50 copay

Anesthesia - continued on next page

Benefit Description	You pay
Anesthesia (cont.)	**Blue Value Plus Option**
	Outpatient Hospital: • PCP – $15 copay • Specialist – $50 copay **Inpatient Hospital:** • 25% of plan allowance

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- **YOUR PHYSICIAN MUST GET PRE-CERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require pre-certification.
- Surgical procedures may involve the services of a co-surgeon, surgical assistant or assistant-at surgery who may bill separately from the primary.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center of the outpatient department of a hospital. Please refer to Section 5(c) for additional information.
- Prior authorization is required for all outpatient services performed in the outpatient department of a hospital.
- If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.
- Prior authorization is not required for Clinic Visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.
- When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are outlined in Sections 5 (a) or (b).
- The Member is responsible for any applicable, Copayment or Coinsurance listed in this schedule.
- When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit.
- If a member chooses an out-of-network facility without prior approval, the member will be responsible for any amount in excess of our allowed benefit. If the admission is urgent or a medical emergency, the member will only be responsible for the per admission copay.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate co-pays and coinsurances

Benefit Description	You pay
Inpatient hospital	**Blue Value Plus**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations; • General nursing care • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	**In-network:** • 25% of plan allowance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Acute Inpatient Rehabilitation • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. • **Note: Hospitalization solely for Acute Rehabilitation is limited to 90 days per benefit period.**	**In-network:** • 25% of plan allowance
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All Charges*
Outpatient hospital or ambulatory surgical center	**Blue Value Plus**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	**In-network:** • Outpatient Hospital (Non-Surgical and Clinic Visit): $50 copay • Freestanding /Ambulatory Surgical Center: $150 copay • Outpatient Hospital (Surgical): $200 copay

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center (cont.)	**Blue Value Plus**
• Professional services, such as those listed in sections 5 (a), that are the sole service and billed by the hospital. Examples include, but are not limited to, covered education classes, physical therapy and cardiac rehabilitation. *Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.* Note: Office visits rendered in a hospital, hospital clinic or health care provider's office visit on a hospital campus are not subject to the facility copay.	**In-network:** • Outpatient Hospital (Non-Surgical and Clinic Visit): $50 copay • Freestanding /Ambulatory Surgical Center: $150 copay • Outpatient Hospital (Surgical): $200 copay
Diagnostic Services such as laboratory tests and pathology services such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	In-Network: • Labs: $50 copay • X-Rays: $100 copay • Other diagnostic services: $100 copay
Specialty Imaging: • MRA/MRS • MRI • PET • CAT scans	In-Network: $150 copay
Extended care benefits/Skilled nursing care facility benefits	**Blue Value Plus**
If a Plan doctor determines that you need full-time skilled nursing care or need to stay in a skilled nursing facility, and we approve that decision, we will give you the comprehensive range of benefits with no dollar or day limit. • Bed, board, and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	**In-Network:** • Facility- 25% of plan allowance
Not covered: • *Custodial care*	*All charges*

Benefit Description	You pay
Hospice care	**Blue Value Plus**
If terminally ill, you are covered for supportive and palliative care in your home or at a hospice. This includes inpatient and outpatient care and family counseling. A Plan doctor, who certifies that you are in the terminal stages of illness, with a life expectancy of approximately six (6) months or less, will direct these services. Respite Care is limited to three (3) periods of 48 hours during the Hospice Eligibility Period. Bereavement Services are provided for up to three (3) visits during the 90 days following the patient's death.	**In-network:** • No Charge
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**Blue Value Plus**
• Local professional ambulance service when medically appropriate • Air ambulance service when medically appropriate. • The in-network cost-share will now be applied to approved out-of-network air ambulance. Members cannot be balanced billed. • Not covered: Air ambulance, unless medically necessary and no other transport is reasonably available.	**In-network:** • $200 copay

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate copays and coinsurances.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Benefits are provided for emergency services that you obtain when you have acute symptoms of sufficient severity-including severe pain-such that a prudent layperson who possesses average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in serious jeopardy to the person's health, serious impairment of bodily function, serious dysfunction of any bodily organ or part, or with respect to a pregnant member, serious jeopardy to the health of the member and/or their unborn child.

If you experience a medical emergency, you should call 911 or go directly to the nearest emergency facility. No authorization is needed for you to receive emergency services. Be sure to tell the workers in the emergency room that you are a Plan member so they can notify the Plan.

Urgent Care:

An urgent condition is a condition that is not a threat to your life, limbs, or bodily organs, but does require prompt medical attention. For urgent situations, please call your primary care provider. If your PCP is unavailable, call FirstHelp a free nurse advice line available 24 hours a day, 7 days a week. Call 800-535-9700 to speak to a registered nurse who will discuss your symptoms and recommend the most appropriate care.

Emergencies inside our service area:

You are encouraged to seek care from Plan providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Plan provider, we will provide benefits for the initial treatment provided in the emergency room of the hospital, even if the hospital is not a plan hospital. If you need to stay in a facility our plan does not designate (a non-Plan facility), you must notify the Plan at (800) 367-1799 or (202) 646-0090 within 48 hours or on the first working day after the day they admitted you, unless you cannot reasonably do so. If you stay in a non-Plan facility and a Plan doctor believes that a Plan hospital can give you better care, then the facility will transfer you when medically feasible and we will fully cover any ambulance charges.

For this Plan to cover you, only Plan-providers can give you follow-up care that the non-Plan providers recommend.

Emergencies outside our service area:

- We will provide benefits for any medically necessary health service that you require immediately because of injury or unforeseen illness.

- If you need to stay in a medical facility, you must notify the Plan at (800) 367-1799 or (202) 646-0090 within 48 hours or on the first working day after the date they admit you, unless not reasonably possible to do so. If a Plan doctor believes a Plan hospital can give you better care, then the facility will transfer you when medically feasible, and we will fully cover any ambulance charges.
- For this Plan to cover you, Plan providers must provide any of the follow-up care that non-Plan providers may recommend to you

Benefit Description	You pay
Emergency Services	**Blue Value Plus Option**
• Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital. Note: For services within the service area and provided by a nonparticipating provider, the member is not responsible for amounts in excess of the allowed benefits. Note: If emergency room and treating physician bill separately, both copays will apply	**In-Network:** • Emergency Room - $275 copay per visit (waived if admitted) • Emergency Room Professional Services - $50 copay per visit • Urgent Care Center - $50 copay per visit Note: Out-of-Network Emergency Room and Professional Services are paid at the In-network level
Not covered: Elective care or non-emergency care	*All charges*
Ambulance	**Blue Value Plus Option**
• Professional ambulance service when medically appropriate. • Air ambulance, when medically necessary. • The in-network cost-share will now be applied to approved out-of-network air ambulance. Members cannot be balanced billed. Note: See 5(c) for non-emergency service.	**In-network:** $200 copay per transport
Not covered: Air ambulance, unless medically necessary and no other transport is reasonably available.	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Cost-sharing and limitations for Plan mental health and substance abuse benefits will be not greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you think you need mental health or substance abuse services, call 800-245-7013 for helping finding a provider.
- Under Standard BlueChoice, when you receive out-of-network care from providers contracted with CareFirst BlueCross BlueShield, but not participating in our BlueChoice network, you are only responsible for the appropriate copays and coinsurances.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- Blue Value Plus has no medical deductible. There is a $100 deductible for Self and $200 deductible for Self Plus One and Self and Family for Pharmacy Tiers 2 - Tiers 5.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate co-pays and coinsurances.

Benefit Description	You pay
Professional services	**Blue Value Option**
• When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Services include: - Outpatient and office medication management - Diagnostic evaluation - Crisis intervention and stabilization for acute episodes - Medication evaluation and management (pharmacotherapy)	In-network: • Inpatient professional - 25% of plan allowance • Office - $15 copay • Outpatient Professional - $50 copay

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**Blue Value Option**
- Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment - Treatment and counseling (including individual or group therapy visits) - Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling - Professional charges for intensive outpatient treatment in a provider's office or other professional setting - Electroconvulsive therapy	In-network: • Inpatient professional - 25% of plan allowance • Office - $15 copay • Outpatient Professional - $50 copay
Inpatient hospital or other covered facility	**Blue Value Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	**In-network:** • 25% of plan allowance
Outpatient hospital or other covered facility	**Blue Value Option**
• Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment Note: Prior authorization is not required for administration of prescription drugs used to treat an opioid use disorder which contain methadone, buprenorphine, or naltrexone, when rendered in the Outpatient Mental Health and Substance Abuse setting	**In-network:** Facility: $50 copay
Not covered:	• *Inpatient admissions not precertified through Case Management* • *Care determined not to meet medically accepted levels of care.*
CareFirst Addiction Program	**Blue Value Option**
The goals of the Alcohol and Drug Addiction Community-Based Program are to: 1. Provide Members with necessary treatments to deliver the best outcomes for their individual clinical circumstances. 2. Provide access to cost effective addiction treatment programs that offer the most up-to-date clinically appropriate standards.	• **CareFirst Preferred Addiction Recovery center** - No cost share for intensive outpatient treatment program • **Other outpatient recovery centers** - Standard out-of-pocket amounts (copay, coinsurance) will apply

CareFirst Addiction Program - continued on next page

Benefit Description	You pay
CareFirst Addiction Program (cont.)	**Blue Value Option**
3. Educate Members, PCPs and all stakeholders as to the causes, identification and treatments of addiction. 4. Provide appropriate care in a community setting outside of a hospital or residential setting to enhance sustainable outcomes and lower costs. Members may receive any of the following services as part of their treatment: • Assessment • Intensive Outpatient Program • Outpatient Detox • Partial Hospital Program (PHP) • Individual Therapy • Group Therapy • Family Therapy • Medication Assisted Treatment (MAT) (includes psychiatrist assessment) Preferred Recovery Centers can be located at https://member.carefirst.com/members/health-wellness/staying-healthy/addiction-program.page	• **CareFirst Preferred Addiction Recovery center** - No cost share for intensive outpatient treatment program • **Other outpatient recovery centers** - Standard out-of-pocket amounts (copay, coinsurance) will apply

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Blue Value Plus has a $100 deductible for Self only enrollment and $200 deductible for Self Plus One enrollment and Self and Family enrollments for pharmacy tiers 2 - 4.
- Out-of-Network: Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies

Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription**. A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them**. You may fill the prescription at a Plan pharmacy, or by mail. You may contact **CVS Health** at **(800) 241-3371** to get more information on the mail order service. We will now require members to fill certain specialty medications within a designated network. Currently the exclusive specialty pharmacy network consists of **CVS/ Caremark**.
- **We use a formulary**. A formulary is a list of covered drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other heatlh care professionals who make sure the drugs on the formulary are safe and clinically effective. Some drugs may be excluded from the formulary and others may require prior authorization from the plan before being filled. Members may request a medical necessity waiver from the plan to obtain medications that require prior authorization or medications that are excluded from formulary.
- **We have a managed formulary**. If your provider believes a name brand product is necessary or there is no generic available, a name brand drug from a formulary list may be prescribed. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, you may contact **CVS Health** at **(800) 241-3371**.
- **These are the dispensing limitations.** You can receive up to 34 days' worth of medication for each fill of prescriptions at a local Plan pharmacy. In addition, you can receive up to 90 days of medications through our mail order pharmacy program or through a local pharmacy, and will pay two (2) copays. Your copay will be $0, $50, $75 or $150 for a 34-day supply or less at the retail pharmacy and twice that amount for 35-day supply or greater up to 90 days. You can purchase the same prescriptions through the mail order service that can be purchased through your community pharmacy. In most cases, you can get a refill once you have taken 75% of the medication. Your prescription will not be refilled prior to the 75% usage guidelines. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Certain drugs require clinical prior authorization. Contact the Plan for a listing of which drugs are subject to the prior authorization policy. Prior authorization may be initiated by the Prescriber or the pharmacy by calling **CVS Health** at **(800) 241-3371**.

- **Why use generic drugs?** A generic drug is the chemical equivalent of a corresponding brand name drug dispensed at a lower cost. You can reduce your out-of-pocket expenses by choosing a generic drug over a brand name drug. Please check the detailed charts in this section to see what you would pay should you get the brand named drug when a generic equivalent is available. If a drug is not available in a generic form, the appropriate brand copay will apply. Mandatory Generic Drug Substitution applies to this plan. If your physician writes "Dispense as Written" for the brand name drug, and you receive a brand name drug when a Federally approved generic drug is available, you will have to pay the difference in cost between the brand name drug and the generic plus the brand copay.
- **When you do have to file a claim**. Call our preferred drug vendor, **CVS Health** at **(800) 241-3371** to order prescription drug claim forms. You will send the prescription drug claim form to: **CVS Health**, **P.O. Box 52136, Phoenix, AZ 85072**.
- **Specialty drugs are covered** exclusively through CVS Specialty. Specialty drugs are high-cost, prescription drugs used to treat serious or chronic medical conditions and require special handling (such as refrigeration), administration or monitoring. Through CVS Specialty, you will receive convenient mail delivery to the address of your choice including your home, doctor's office or a CVS Pharmacy location. CVS Specialty provides your specialty drugs and personalized pharmacy care management services including:
  - Access to a team of clinicians specially trained in your condition
  - On-call pharmacist 24 hours a day, seven days a week
  - Coordination of care with you and your doctor
  - Drug and condition-specific education and counseling
  - Insurance and financial coordination assistance
- **Your doctor may send a prescription to CVS Specialty via e-prescription, phone (800-799-0692), or fax (855-296-0210).**

There are important features you should be aware of. These include:

- **Who can write your prescription**. A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them**. You may fill the prescription at a plan pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy. – or – You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication
- **We use a formulary**. We cover non-formulary drugs prescribed by a Plan doctor.
- We have a managed formulary. If your provider believes a name brand product is necessary or there is no generic available, your provider may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call (800)-241-3371.
- **These are the dispensing limitations**.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- Why use generic drugs.
- When you do have to file a claim.

Benefit Description	You pay
Covered medications and supplies	**Blue Value Plus Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to: Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Drugs to treat gender dysphoria - The following drug classes are typically used for gender dysphoria and are covered regardless of gender designation: • Progestins • Gonadotropin-Releasing Hormone Agonists • Aldosterone Antagonists, Selective • Antineoplastics, Antiandrogens • Oral Contraceptives • Estrogen Derivatives • Androgens • Drugs for anti-obesity based on medical necessity and require prior authorization • IVF drugs based on medical necessity and require prior authorization Note: Infertility is the inability to conceive or produce conception after 1 year of unprotected sex when an individual is under 35 years of age, or 6 months for an individual age 35 or older or failed attempts at artificial insemination. There are various reproductive treatments available for people facing infertility, which are customized according to their medical history and diagnostic results. Note: Specialty Drugs are typically high in cost and have one or more of the following characteristics: • Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology • Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects • Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy	There is a $100 Self Only enrollment deductible and $200 Self Plus One and Self and Family enrollments deductible for pharmacy for the Blue Value Plus option on Tiers 2 - Tiers 4 Retail: up to 34-day supply per copay: Tier 1 Preferred generics - $10 copay, no deductible Tier 2 Preferred brand - Deductible, then $50 copay Tier 3 Preferred specialty generic - Deductible, then $100 copay Tier 4 preferred specialty brand - Deductible, then $150 copay Preferred brand Insulin - No deductible, then $30 copay Opioid Reversal Agents- No deductible, then $0 copay Maintenance Drugs Up to 90-day supply per copayment: Tier 1 Preferred generics - $20 copay, no deductible Tier 2 Preferred brand - Deductible, then $100 copay Tier 3 Preferred specialty generic - Deductible, then $200 copay Tier 4 preferred specialty brand - Deductible, then $300 copay

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Blue Value Plus Option**
• Unique patient compliance and safety monitoring requirements • Unique requirements for handling, shipping, and storage • Intravenous fluids and medications for home use, implantable drugs (such as Norplant), some injectable drugs (such as Depo Provera), and IUDs are covered under the Medical and Surgical Benefits • Specialty drugs require pre-authorization and the use of preferred pharmacies • Glucometers are covered as Durable Medical Equipment under the Medical and Surgical Benefits. See page xxx • Specialty drugs are limited to a 34-day supply for the first initial fill	There is a $100 Self Only enrollment deductible and $200 Self Plus One and Self and Family enrollments deductible for pharmacy for the Blue Value Plus option on Tiers 2 - Tiers 4 Retail: up to 34-day supply per copay: Tier 1 Preferred generics - $10 copay, no deductible Tier 2 Preferred brand - Deductible, then $50 copay Tier 3 Preferred specialty generic - Deductible, then $100 copay Tier 4 preferred specialty brand - Deductible, then $150 copay Preferred brand Insulin - No deductible, then $30 copay Opioid Reversal Agents- No deductible, then $0 copay Maintenance Drugs Up to 90-day supply per copayment: Tier 1 Preferred generics - $20 copay, no deductible Tier 2 Preferred brand - Deductible, then $100 copay Tier 3 Preferred specialty generic - Deductible, then $200 copay Tier 4 preferred specialty brand - Deductible, then $300 copay
The following prescription drugs are covered in full: - Chemotherapy medications received through a pharmacy - Preventive Breast Cancer drugs for women who are at an increased risk for breast cancer, and at a low risk for adverse medication effects Please refer to our website www.carefirst.com/pshb for any updates to this list and for additional information on how these items are covered.	No copay
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy.	No copay

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Blue Value Plus Option**
• Preventive Services Contraceptive Zero Copay Exception criteria is intended to allow the member to receive a $0 member cost share for any Health Care Reform preventive services contraceptive product not already covered at a $0 member cost share when determined to be medically necessary. To request the exception your provider should contact CVS directly via phone or fax the Exception Request Form. A response will be provided within 24hrs of receiving the completed Exception Request Form. • If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a)	No copay
Not covered • Drugs and supplies for cosmetic purposes • Drugs to enhance athletic performance • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Nonprescription medications	*All charges*
Preventive medications	**Blue Value Plus Option**
The following are covered: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations Preventive Care medications to promote better health as recommended by ACA includes the following: • Men and women ages 40 through 75 years old • No quantity limit • No prior authorization • Low to moderate dose statins, generics only (no high dose or brand statins are included) The following generic drugs are covered without cost-share as prescribed by a health care professional and filled at a network pharmacy and will be made available as follows: • Atorvastatin 10 mg, 20 mg	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.

Preventive medications - continued on next page

Benefit Description	You pay
Preventive medications (cont.)	**Blue Value Plus Option**
• Fluvastatin 20 mg, 40 mg • Fluvastatin ER 80 mg • Lovastatin 10 mg, 20 mg, 40 mg • Pravastatin 10 mg, 20 mg, 40 mg, 80 mg • Rosuvastatin 5 mg, 10 mg • Simvastatin 5 mg, 10 mg, 20 mg, 40 mg Note: For statin prescriptions outside of these age ranges and/or strengths our standard plan benefits will apply.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Smoking deterrents Note: Medications approved by the FDA to treat tobacco dependence are covered under the tobacco and nicotine cessation benefits and dispensed under our pharmacy program. To be covered, the medications must be prescribed by a physician, even if it is available over-the counter.	No charge, up to two (2) attempts per year.
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a plan pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www.findtreatment.samhsa.gov/.	No deductible, then $0 copay
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	All charges

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at (833) 489-1316.
- The plan name for your PDP EGWP coverage is CareFirst BlueCross BlueShield Group Medicare Rx (PDP).

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- Your plan offers coverage for prescription drugs on a Medicare formulary (drug list). This is considered the Primary / Medicare Prescription Drug Coverage. If your drug is not covered on the Medicare formulary, your plan offers secondary coverage as well. The plan includes additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan.

We cover drugs, medications, and supplies as described below and on the following pages.

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.
- The Medicare Part D calendar year deductible is: $100 per person. This deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.
- Members will enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.
- Use a network pharmacy

		• Out-of-Network: Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies. • Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage. • If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at (833) 489-1316. **Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.** **Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at (833) 489-1316.** **----------** Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, and a mail order form will be accessible at www.carefirst.com/pshbp. You can also obtain a copy of the Evidence of Coverage for your CareFirst BlueCross BlueShield Group Medicare Rx (PDP) plan at www.carefirst.com/pshbp.	

There are important features you should be aware of. **These include:**

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You may fill prescriptions at any network pharmacy. For assistance locating a PDP EGWP network pharmacy, visit our website at www.carefirst.com/pshbp, or call us at (833) 840-7962.
- **We have a managed formulary.** Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. You may view our formulary on our website at www.carefirst.com/pshbp or call us at (833) 840-7962.
- **These are the dispensing limitations** You can receive up to 34 days' worth of medication for each fill of prescriptions at a local Plan pharmacy. In addition, you can receive up to 90 days of medications through our mail order pharmacy program or through a local pharmacy, and will pay two (2) copays. In most cases, you can get a refill once you have taken 75% of the medication. Your prescription will not be refilled prior to the 75% usage guidelines. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Contact the Plan for a listing of which drugs are subject to the prior authorization policy. Prior authorization may be initiated by the Prescriber or the pharmacy by calling **CVS Health** at **(833) 840-7962**.
- **We may require** Utilization Management strategies. Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:
  - **Prior Authorization:** CareFirst BlueCross BlueShield Group Medicare Rx (PDP) requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from CareFirst BlueCross BlueShield Group Medicare Rx (PDP) before you fill your prescriptions. If you don't get approval, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) may not cover the drug.
  - **Quantity Limits:** For certain drugs, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) limits the amount of the drug that CareFirst BlueCross BlueShield Group Medicare Rx (PDP) will cover.
  - **Step Therapy:** In some cases, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) may not cover Drug B unless you try Drug A first. If Drug A does not work for you, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) will then cover Drug B.

- **You may request a Formulary Exception.** You can ask CareFirst BlueCross BlueShield Group Medicare Rx (PDP) to make an exception to our coverage rules.
  - You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
  - You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.
  - You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

    Generally, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

    You or your prescriber should contact us to ask for a tiering or, formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

    How to Request a Coverage Determination

    A member, prescriber, or a member's appointed representative may request a standard or expedited coverage determination. You, your prescriber or your appointed representative may request a coverage decision and/or exception any of the following ways:

    Phone:

    Contact customer service for any requests including making an oral request related to Coverage Determination and Appeals. Our customer service team is available 24/7/365 at 833-840-7962. Appeals calls are then redirected to the correct department for further action. Other means of contact are provided below.

    Fax: 855-633-7673

    Online: Coverage Determination Form

    Mail:

    CVS Caremark Coverage Determinations/Exceptions
    P.O. Box 52000
    Phoenix, AZ 85072-2000

- **We have a closed formulary for the Blue Value Plus option.** If your provider believes a drug is necessary that is excluded from our formulary based on medical necessity, an exception may be available. Members may request a medical necessity waiver from the Plan to obtain medications that require prior authorization or medications that are excluded from the formulary.
- **Why use generic drugs.** A generic drug is the chemical equivalent of a corresponding brand name drug dispensed at a lower cost. You can reduce your out-of-pocket expenses by choosing a generic drug over a brand name drug. Please check the detailed charts in this section to see what you would pay should you get the brand named drug when a generic equivalent is available. If a drug is not available in a generic form, the appropriate brand copay will apply.
- **When you do have to file a claim.** Call our preferred drug vendor, **CVS Health** at **(833) 840-7962** to order prescription drug claim forms. You will send the prescription drug claim form to: **CVS Health**, **P.O. Box 52136, Phoenix, AZ 85072.**

- **If we deny your claim and you want to appeal**, you, your representative, or your prescriber must request an appeal following the process described in Section 8(a). Medicare PDP EGWP Disputed Claims Process. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.
- **Specialty drugs are covered** exclusively through CVS Specialty. Specialty drugs are high-cost, prescription drugs used to treat serious or chronic medical conditions and require special handling (such as refrigeration), administration or monitoring. Through CVS Specialty, you will receive convenient mail delivery to the address of your choice including your home, doctor's office or a CVS Pharmacy location. CVS Specialty provides your specialty drugs and personalized pharmacy care management services including:
  - Access to a team of clinicians specially trained in your condition
  - On-call pharmacist 24 hours a day, seven days a week
  - Coordination of care with you and your doctor
  - Drug and condition-specific education and counseling
  - Insurance and financial coordination assistance

PDP EGWP Catastrophic Maximum

The PDP EGWP Catastrophic Maximum of $2,000 is the most you would need to spend each year on medications covered by your plan before you reach the Catastrophic Coverage Stage. The amounts you spend on your primary and secondary prescription drug benefits count toward this maximum. These amounts will also count towards your Maximum Out of Pocket (also known as Catastrophic Protection Out of Pocket Maximum).

Benefit Description	You pay
Covered medications and supplies	**Blue Value Plus Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to: Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Drugs to treat gender dysphoria - The following drug classes are typically used for gender dysphoria and are covered regardless of gender designation: • Progestins • Gonadotropin-Releasing Hormone Agonists • Aldosterone Antagonists, Selective • Antineoplastics, Antiandrogens • Oral Contraceptives • Estrogen Derivatives • Androgens	Your plan offers coverage for prescription drugs on a Medicare formulary (drug list). This is considered your Primary / Medicare Prescription Drug Coverage. If your drug is not covered on the Medicare formulary, your plan offers secondary coverage as well. Your plan includes additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. Search this plan's Medicare Part D formulary. If your prescription drug is not covered on the Medicare formulary, you will need to check the CareFirst Prescription Formulary 4 for your drug. The formulary files can be found at www.carefirst.com/pshbp. If the drug is covered under both formularies your will pay the lesser of the applicable cost share listed below. **Medicare Part D Prescription Drug Benefits:** Retail: up to 30-day supply per copay: • Tier 1: Preferred Generic: $10 copay • Tier 2: Generic: $10 copay • Tier 3: Preferred Brand: $50 copay • Tier 4: Non-Preferred Drug: deductible then, $100 copay • Tier 5: Specialty Tier: deductible then, $150 copay Maintenance Drugs Up to 90-day supply per copayment: • Tier 1: Preferred Generic: $20 copay • Tier 2: Generic: $20 copay

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Blue Value Plus Option**
• Drugs for anti-obesity based on medical necessity and require prior authorization • IVF drugs based on medical necessity and require prior authorization Note: Infertility is the inability to conceive or produce conception after 1 year of unprotected sex when an individual is under 35 years of age, or 6 months for an individual age 35 or older or failed attempts at artificial insemination. There are various reproductive treatments available for people facing infertility, which are customized according to their medical history and diagnostic results. Note: Specialty Drugs are typically high in cost and have one or more of the following characteristics: • Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology • Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects • Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy • Unique patient compliance and safety monitoring requirements • Unique requirements for handling, shipping, and storage • Intravenous fluids and medications for home use, implantable drugs (such as Norplant), some injectable drugs (such as Depo Provera), and IUDs are covered under the Medical and Surgical Benefits • Specialty drugs require pre-authorization and the use of preferred pharmacies • Glucometers are covered as Durable Medical Equipment under the Medical and Surgical Benefits. See page • Specialty drugs are limited to a 34-day supply for the first initial fill	Your plan offers coverage for prescription drugs on a Medicare formulary (drug list). This is considered your Primary / Medicare Prescription Drug Coverage. If your drug is not covered on the Medicare formulary, your plan offers secondary coverage as well. Your plan includes additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. Search this plan's Medicare Part D formulary. If your prescription drug is not covered on the Medicare formulary, you will need to check the CareFirst Prescription Formulary 4 for your drug. The formulary files can be found at www.carefirst.com/pshbp. If the drug is covered under both formularies your will pay the lesser of the applicable cost share listed below. **Medicare Part D Prescription Drug Benefits:** Retail: up to 30-day supply per copay: • Tier 1: Preferred Generic: $10 copay • Tier 2: Generic: $10 copay • Tier 3: Preferred Brand: $50 copay • Tier 4: Non-Preferred Drug: deductible then, $100 copay • Tier 5: Specialty Tier: deductible then, $150 copay Maintenance Drugs Up to 90-day supply per copayment: • Tier 1: Preferred Generic: $20 copay • Tier 2: Generic: $20 copay • Tier 3: Preferred Brand: $100 copay • Tier 4: Non-Preferred Drug: deductible then, $200 copay • Tier 5: Specialty Tier: Not Covered Note: Under the Medicare Part D Prescription Drug Benefits if a prescriber writes "Dispense as Written" for the brand name drug, and the member receives a brand name drug when a Federally approved generic drug is available, the member will pay the brand copay. **Secondary Coverage: Blue Value Plus Formulary 4 Prescription Benefits** Retail: up to 34-day supply per copay: Tier 1 Preferred generics - $10 copay, no deductible Tier 2 Preferred brand - Deductible, then $50 copay Tier 3 Preferred specialty generic - Deductible, then $100 copay Tier 4 preferred specialty brand - Deductible, then $150 copay Preferred brand Insulin - No deductible, then $30 copay Opioid Reversal Agents- No deductible, then $0 copay

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Blue Value Plus Option**
	Maintenance Drugs Up to 90-day supply per copayment: Tier 1 Preferred generics - $20 copay, no deductible Tier 2 Preferred brand - Deductible, then $100 copay Tier 3 Preferred specialty generic - Deductible, then $200 copay Tier 4 preferred specialty brand - Deductible, then $300 copay
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Preventive Services Contraceptive Zero Copay Exception criteria is intended to allow the member to receive a $0 member cost share for any Health Care Reform preventive services contraceptive product not already covered at a $0 member cost share when determined to be medically necessary. To request the exception your provider should contact CVS directly via phone or fax the Exception Request Form. A response will be provided within 24hrs of receiving the completed Exception Request Form. • If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a)	$0 copay
The following prescription drugs are covered in full: - Chemotherapy medications received through a pharmacy - Preventive breast cancer drugs for women who are at an increased risk for breast cancer, and at a low risk for adverse medication effects Please refer to our websitewww.carefirst.com/pshbp for any updates to this list and for additional information on how these items are covered.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Not covered • Drugs and supplies for cosmetic purposes	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Blue Value Plus Option**
• Drugs to enhance athletic performance • Drugs obtained at a non-Plan pharmacy; except for out of area emergencies • Nonprescription medications	*All charges*
Preventive medications	**Blue Value Plus Option**
The following are covered: • Preventive Medications with a USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Preventive Care medications to promote better health as recommended by ACA includes the following: • Men and women ages 40 through 75 years old • No quantity limit • No prior authorization • Low to moderate dose statins, generics only (no high dose or brand statins are included) The following generic drugs are covered without cost-share as prescribed by a health care professional and filled at a network pharmacy and will be made available as follows: • Atorvastatin 10 mg, 20 mg • Fluvastatin 20 mg, 40 mg • Fluvastatin ER 80 mg • Lovastatin 10 mg, 20 mg, 40 mg • Pravastatin 10 mg, 20 mg, 40 mg, 80 mg • Rosuvastatin 5 mg, 10 mg • Simvastatin 5 mg, 10 mg, 20 mg, 40 mg Note: For statin prescriptions outside of these age ranges and/or strengths our standard plan benefits will apply.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Smoking deterrents Note: Medications approved by the FDA to treat tobacco dependence are covered under the tobacco and nicotine cessation benefits and dispensed under our pharmacy program. To be covered, the medications must be prescribed by a physician, even if it is available over-the-counter.	No Charge, up to two (2) attempts per year

Preventive medications - continued on next page

Benefit Description	You pay
Preventive medications (cont.)	**Blue Value Plus Option**
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a plan pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www.findtreatment.samhsa.gov/	$0 copay
Not covered: • Drugs and supplies for cosmetic purposes • Drugs to enhance athletic performance • Fertility drugs • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Nonprescription medications	All charges

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be first/primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. *See Section 9*, Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Accidental injury benefit	**Blue Value Plus Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	**In-network:** • PCP - $10 copay • Specialist - $50 copay
Dental benefits	**Blue Value Plus Option**
We have no other dental benefits	Not covered

Section 5(h). Wellness and Other Special Features

Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hour nurse line	If your PCP is unavailable, call FirstHelp a free nurse advice line available 24 hours a day, 7 days a week. Call 800-535-9700 to speak to a registered nurse who will discuss your symptoms and recommend the most appropriate care.
Services for deaf and hearing impaired	Our TTY number for Customer Service is (202) 479-3546
Care Team Program	We provide programs for members diagnosed with coronary artery disease, congestive heart failure, diabetes, cancer, asthma and other chronic conditions. These programs are designed to help you better understand and manage your condition. Our Care Team Program benefits may include: • Educational materials, such as self-monitoring charts, resource listings, self-care tips, and a quarterly newsletter • A health assessment and nurse consultation • Access to a 24-hour Nurse Advisor help line Please call us at (800) 783-4582 for more information about our Care Team Program
Away from Home Care Program	If you or one of your covered family member move outside of our service area for an extended period of time (for example, if your child goes to college in another state), you may be able to take advantage of our Guest Membership Program. This program would allow you or your dependents the option to utilize the benefits of an affiliated BlueCross BlueShield HMO. Please contact us at (888) 452-6403 for more information on the Guest Membership Program.

Visit our expanded web option www.carefirst.com/pshbp	**M*y Account*** This tool gives members access to their claims and benefit eligibility information when they log in to the secure, password-protected site. Each covered member over the age of 14 may create their own user ID and password. After creating a password, members can: • View who is covered under their contract • Current and historical claims status • Order a new ID card Prescription Drug Benefits section includes information for prospects and members including: • Formulary List • BlueChoice Select Generic List Additional features include: • Drug pricing tool • Hospital comparison tool • Treatment cost estimator • Provider Directory with special information • Health Risk Assessment ***My CareFirst*** This is our member health and wellness section. Here you can find: • Health Library of Medical Conditions • Health Lifestyle Section-Nutrition, Fitness, etc. • Personal Health page, with tracking tools and assistance setting health and wellness goals
Telephonic Health Coaching	The healthy lifestyle coaching program fills a void between healthy employees and those who suffer from chronic diseases. Employees who are at high risk for future disease as identified by MyHealth Profile are invited to participate in healthy lifestyle coaching sessions. These are scheduled phone conversations where employees develop a relationship with a clinician (health coach) trained in Motivational Interviewing and in Behavior Change Theory. The health coach identifies a number of factors including the employee's existing barriers to change and their readiness to change. The health coach then helps the employee set achievable short-term and long-term goals so they can make a permanent change in health behavior.
BlueRewards	Financial incentives can effectively encourage Members to take an active role in their own health. Through Blue Rewards - the CareFirst Health and Wellness Incentive Program - Members can earn a reward for completing specific activities that increase the likelihood of success in their wellness efforts. The Blue Rewards incentive program will include Subscribers and Spouse/Domestic Partners for all CareFirst medical plans to encourage initial and ongoing engagement. Blue Rewards will feature three types of rewards 1) participation-based rewards, 2) ongoing rewards, and 3) coaching rewards: Both you and your spouse/domestic partner will be rewarded for completing one, or all of the following activities: 1. Choose a PCP AND complete their health screening with your PCP or at a CVS MinuteClinic to earn $100. You must complete within 180 days of your effective date.

	2. Complete a health assessment AND provide consent to receive wellness related communications (emails) to earn $50. You must complete within 180 days of your effective date. 3. Retake by updating/confirming responses to your health assessment. Answers must be updated or confirmed no earlier than 90 days after the original assessment, and before the end of the benefit period to earn $50. 4. Participate in Health Coaching Sessions. You may earn rewards for completing one (1), two (2), or three (3) coaching sessions. Completing coaching sessions are based on member participation and not dependent on achieving an outcome and/or health-related goal. Only one (1) coaching session per 2-60 days will count towards an incentive. A maximum of three (3) coaching sessions per Benefit Period will count towards the incentive. Members will receive their incentive in the form of a medical expense debit card to help pay for deductibles, copays, and coinsurance for CareFirst health, pharmacy, vision, and dental costs. The debit card reduces barriers to care and is preloaded with Merchant Category Codes (MCC) for eligible medical expenses that dictate whether the card will work at a specific location. If the member tries to use the card at a location where the MCC is not loaded, the card will reject the charge. To get started, visit www.carefirst.com/wellbeing. You'll need to complete the one-time registration to link your CareFirst account information. This will help personalize your experience.
SmartShopper Program	The SmartShopper incentive and engagement Program is available to Subscribers and Spouses for all CareFirst medical plans. A Member is eligible to participate in the program if they require a specific treatment or procedure as specified by CareFirst. A Member is able to utilize the SmartShopper Program by means of CareFirst's integrated digital tool or by calling 888-345-2873 and speaking with a member of the Personal Assistant Team ("PAT"). Members are able to earn rewards for selecting the most cost-effective providers and site of service for care. A Member will receive an incentive for each service or category of Comparable Health Care Service resulting from comparison shopping and there is no limit on the Incentive amount(s) a member may earn in the benefit period. Members will receive their incentive in the form of a medical expense debit card to help pay for deductibles, copays, and coinsurance for CareFirst health, pharmacy, vision, and dental costs. Members who choose the high-deductible health plan option, and choose to fund their account, are not allowed to use their card funds for eligible medical and/or prescription expenses until first satisfying their IRS minimum deductible. However, these members can use the card funds for eligible dental and or vision expenses that are part of the benefit plan.
Ovia Health	Included with your CareFirst WellBeing program for members 18 and over, Ovia offers support for reproductive health, including conceiving, pregnancy, post- partum, parenting, and perimenopause/ menopause. Users will choose their goal and Ovia will customize the member experience to deliver personalized insights, tips and content - which includes access to Care Advocates and coaches specializing in reproductive health. Follow these steps to get started today! 1. Log in to your CareFirst WellBeing account (or create one at www.carefirst.com/wellbeing) 2. Under Achieve, choose Programs to view your women's health programs 3. Select Ovia and follow the prompts to get started 4. Download the Ovia app and explore

Section 5. BlueChoice Advantage HDHP Benefits

Section 5. BlueChoice Advantage HDHP Overview

This Plan offers a High Deductible Health Plan (HDHP). The BlueChoice Advantage HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

The BlueChoice Advantage HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read **important things you should keep in mind about these benefits** at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about BlueChoice Advantage HDHP benefits, contact us at (888) 789-9065 or on our website at www.carefirst.com/pshbp.

Our BlueChoice Advantage HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your healthcare benefits.

When you enroll in BlueChoice Advantage HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment. If the member does not open an account within 30 days of receiving the HSA application/forms, their funds will automatically be defaulted into an HRA account.

To register for or log in to your CareFirst My Account: Go to www.carefirst.com/pshbp. To the far right, click on the LOGIN/REGISTER link. This will automatically direct you to the Welcome to My Account page. To register—select Register. This will take you to the User Details screen where you will be asked to enter your Member ID number. Follow the prompts to create a User ID, password and answer security questions. If you already have an account register, click on Login and enter your User ID and password.

If you do not have access to the internet, call Member Service at 833-489-1316 and let them know which option (HSA or HRA) you want to enroll in. They will document your selection. **As a reminder, once you are enrolled into your plan year benefits, you cannot change your HRA to an HSA election until the next annual Open Enrollment period.**

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 100. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

BlueChoice Advantage HDHP includes five (5) key components: Preventive care; traditional medical coverage healthcare that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools

- **Preventive care** — The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are described in Section 5 *Preventive care. You do not have to meet the deductible before using these services.*

- **Traditional medical coverage** — After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays a higher copay after the deductible for out-of-network care that applies to in-network services.

  Covered services include:

  - Medical services and supplies provided by physicians and other healthcare professionals
  - Surgical and anesthesia services provided by physicians and other healthcare professionals
  - Hospital services; other facility or ambulance services

- Emergency services/accidents
- Mental health and substance abuse benefits
- Prescription drug benefits
- Dental benefits

- **Savings**

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses

- **Health Savings Accounts (HSAs)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits within the last three months or do not have other health insurance coverage other than another High Deductible Health Plan. In 2025, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $75 per month for a Self Only or $150 per month for a Self Plus One or a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $4,300 for an individual and $8,550 for a family. See maximum contribution information on page 94. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It is portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire

Important consideration if you want to participate in a Healthcare Flexible Spending Account (HCFSA): If you are enrolled in BlueChoice Advantage HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA healthcare flexible spending account, BlueChoice Advantage HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you

- **Health Reimbursement Arrangements (HRA)**

If you are not eligible for an HSA, for example, you are enrolled in Medicare or have another health plan; we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA as soon as possible.

In 2025, we will give you an HRA credit of $900 per year for a Self Only enrollment, or $1,800 per year for a Self Plus One enrollment, or $1,800 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that do not count toward the deductible.

HRA features include:

- For BlueChoice Advantage HDHP, the HRA is administered by Further by Health Equity.
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by BlueChoice Advantage HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in a Healthcare Flexible Spending Account (HCFSA). However, you must meet HCFSA eligibility requirements.

- **Catastrophic protection for out-of-pocket expenses**

When you use in-network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,500 for Self Only enrollment and $11,000 for Self Plus One, or Self and Family enrollment, and out-of network care is limited to $7,500 for Self Only enrollment and $15,000 for Self Plus One or Self and Family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4, *Your catastrophic protection out-of-pocket maximum* and BlueChoice Advantage HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details. If you are enrolled in our PDP EGWP, see page 154 for additional information about your out-of-pocket maximum.

Out-Of-Pocket Maximum

- **Individual Coverage:**
  - The member must meet the individual out-of-pocket maximum.
- **Family Coverage:**
  - Each member can satisfy their own individual out-of-pocket maximum by meeting the individual out-of-pocket maximum. In addition, eligible expenses of all covered family members can be combined to satisfy the Self and Family out-of-pocket maximum.
  - An individual family member cannot contribute more than the individual out-of-pocket maximum toward meeting the Self and Family out-of-pocket maximum
- Once the family out-of-pocket maximum has been met, this will satisfy the out-of-pocket maximum for all family members. These amounts apply to the out-of-pocket maximum:
  - Co-payments and coinsurance for all covered services
  - Prescription drug benefit Rider co-payments and coinsurance for all covered services
  - Deductible

- **Note**: When the member has reached the out-of-pocket maximum, no further co-payments, coinsurance or deductible will be required in that benefit period for covered services. The in-network and out-of-network out-of-pocket maximum contributes towards one another.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your healthcare and your healthcare dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with our BlueFund Administrator**,** BlueChoice Advantage HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	Further by Health Equity is the HRA fiduciary for this Plan.
Fees	Set-up fee is paid by the BlueChoice Advantage HDHP. No per month administrative fee charged by the fiduciary and taken out of the account balance as long as you are enrolled in the plan.	None.
Eligibility	You must: • Enroll in BlueChoice Advantage HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits in the last three (3) months • Enroll in the HSA, as contracted and communicated within 30 days from their effective date • Exceptions will only be considered if there are special circumstances (ex: for a high-ranking official)	You must enroll in BlueChoice Advantage HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment. .
Funding		Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.

	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the BlueChoice Advantage HDHP. Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month. Except for members enrolled during open enrollment with an effective date after the 1st in the month of January. These members will still receive the January premium contribution. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	
• **Self Only enrollment**	For 2025, a monthly premium pass through of $75 will be made by the BlueChoice Advantage HDHP directly into your HSA each month.	For 2025, your HRA annual credit is $900 (prorated for mid-year enrollment).
• **Self Plus One enrollment**	For 2025, a monthly premium pass through of **$150** will be made by the BlueChoice Advantage HDHP directly into your HSA each month	For 2025, your HRA annual credit is **$1,800** (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2025, a monthly premium pass through of **$150** will be made by the BlueChoice Advantage HDHP directly into your HSA each month.	For 2025, your HRA annual credit is **$1,800** (prorated for mid-year enrollment).
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of the BlueChoice Advantage HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $4,300 for an individual $8,550 for a family.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your BlueChoice Advantage HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12-month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to the BlueChoice Advantage HDHP HSA (rollover funds do not affect your annual maximum contribution under BlueChoice Advantage HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution).	
• **Self Only enrollment**	In addition to the pass through contribution, you may make an annual maximum contribution of $3,400.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	In addition to the pass through contribution, you may make an annual maximum contribution of $6,750.	You cannot contribute to the HRA.
• **Self and Family enrollment**	In addition to the pass through contribution, you may make an annual maximum contribution of $6,750.	You cannot contribute to the HRA.
Access funds	Members may access HSA funds by the following methods: • Debit card (default option) • Auto-pay (member may elect this option online)	Members may access HRA funds by the following methods: • Debit card (default option) • Auto-pay (member may elect this option online)

	• Withdrawal form (check or direct deposit) • Online claims: • Get reimbursed (payment to member) • Pay a bill (payment to provider) • Debit cards are automatically sent to members upon enrollment. Members have the option to elect auto-pay instead of debit card, but members may only choose one of these options. • Debit cards may be used at the point-of-service for immediate access to available funds. • Auto-pay claims are processed systematically and do not require manual claims submission. Members pay for out-of-pocket expenses and are then reimbursed for eligible expenses from available funds once the claim is processed. Withdrawal forms and online reimbursement options are both available when the member is enrolled in either Debit card or Auto-pay.	• Withdrawal form (check or direct deposit) • Online claims: • Get reimbursed (payment to member) • Pay a bill (payment to provider) • Debit cards are automatically sent to members upon enrollment. Members have the option to elect auto-pay instead of debit card, but members may only choose one of these options. • Debit cards may be used at the point-of-service for immediate access to available funds. • Auto-pay claims are processed systematically and do not require manual claims submission. Members pay for out-of-pocket expenses and are then reimbursed for eligible expenses from available funds once the claim is processed. Withdrawal forms and online reimbursement options are both available when the member is enrolled in either Debit card or Auto-pay.
Distributions/withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the BlueChoice Advantage HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the BlueChoice Advantage HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publications 502 and 969 for information on eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.

• **Non-medical**	If you are under age 65, distributions/ withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions/ withdrawal can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in BlueChoice Advantage HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) • The BlueChoice Advantage HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you	The entire amount of your HRA will be available to you upon your enrollment in the BlueChoice Advantage HDHP.
Account owner	PSHB enrollee	BlueChoice Advantage HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA	If you retire and remain in BlueChoice Advantage HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under BlueChoice Advantage HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season your effective date is January 1st, or if you enroll at any other time and have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability

- **Over age 55 additional contributions**

  If you are age 55 or older, the IRS permits you to make additional contributions to your HSA. The allowable additional contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the IRS website at www.irs.gov or request a copy of IRS Publication 969 by calling 1-800-829-3676. www.ustreas.gov/offices/public-affairs/hsa/

- **If you die**

  If you have not named beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For detailed information of IRS-allowable expenses, request a copy of IRS Publication 502 and 969 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You will receive a periodic statement that shows the "premium pass through", withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least $25.

If you have an HRA

- **Why an HRA is established** — If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.
- **How an HRA differs** — Please review the chart on page 96 which details the differences between an HRA and an HSA. The major differences are:
  - you cannot make contributions to an HRA
  - funds are forfeited if you leave the HDHP
  - an HRA does not earn interest
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. PSHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

- In-network preventive care services listed in this Section are not subject to the deductible.
- You must use providers that are part of our network.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible*.
- When seeing providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.

Benefit Description	You pay
Preventive care, adult	
Routine physicals allowed once per benefit period including screenings. The **following** preventive services are covered at the time interval recommended at each of the links below: • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Genetic Testing: Prior Authorization is required for genetic testing. Ordering providers must obtain authorization for all genetic tests either by accessing the CareFirst provider portal under Pre-Auth/ Notifications or calling AIM directly at (844) 377-1277. HLA Typing/Preimplantation (related to in vitro fertilization) may require authorization through the health plan and can be managed in CareFirst's provider portal under Medical Prior Authorization and no authorization is required for Cologuard®.	**In-network:** • No Copay **Out-of-network:** • Calendar year deductible applies • No Copay

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
• Routine mammogram • Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules/	**In-network:** • No copay **Out-of-network:** • No copay
• Routine exams limited to: - One (1) routine eye exam every 12 months - One (1) routine OB/GYN exam every 12 months including one (1)Pap smear and related services - One (1) routine hearing exam every 24 months	**In-network:** • No copay **Out-of-network:** • Calendar year deductible applies • No copay
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Note: • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) or 5(f)(a) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share. • Also see Section 5(h) for additional programs that offer nutritional and physical activity support.	**In-network:** • No copay **Out-of-network:** • Calendar year deductible applies • No copay
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All charges*

Benefit Description	You pay
Preventive care, children	
Well-child visits examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at: www.uspreventiveservicestaskforce.org HHS: www.healthcare.gov/preventive-care-benefits/ ACIP recommendations on immunizations, please refer to the National Immunization Program Web site at: www.cdc.gov/vaccines/schedules/index.html CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: www.healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to www.brightfutures.aap.org/Pages/default.aspx	**In-network:** • No copay **Out-of-network:** • Calendar year deductible applies • No copay
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Note When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	**In-network:** • No copay **Out-of-network:** • Calendar year deductible applies • No copay
Not covered:	All charges

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
• *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Immunizations, boosters, and medications for travel*	All charges
Dental Preventive Care	
Preventive care limited to: • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year • Fluoride applications (limited to 1 treatment per calendar year and for children under age 16) • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing X-ray s (one set per calendar year) • Complete series X-rays (one complete series every 3 years) • Periapical X-rays • Routine oral evaluations (limited to 2 per calendar year)	All charges

Section 5. Traditional Medical Coverage Subject to the Deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% and is not subject to the calendar year deductible
- The deductible is $1,650 per Self Only enrollment, $3,300 per Self Plus One and Family enrollment for in-network services. The deductible is $3,300 per Self Only enrollment, or $6,600 per Self Plus One and Self and Family enrollment for out-of-network care.
- The family deductible can be satisfied by one or more family members.
- The in-network and out-of-network deductibles contribute towards one another.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center of the outpatient department of a hospital. Please refer to Section 5(c) for additional information.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts or co-payments for eligible medical expenses and prescriptions until you have reached our annual out of pocket maximum.
- When the allowed benefit for any covered service is less than the co-payment listed, the member payment will be the allowed benefit.
- Prior authorization is required for all outpatient services performed in the outpatient department of a hospital.
- If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-covered service.
- Prior authorization is not required for clinic visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.
- When multiple services are rendered on the same day by more than one provider, member copayments are required for each provider.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and co-pays and coinsurances.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $5,500 per person, $11,000 per Self Plus One enrollment or $11,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance). See page 154 if you are enrolled in our Medicare Prescription Drug Plan (PDP).

Benefit Description	You Pay
Deductible before Traditional medical coverage begins	**HDHP**
The deductible applies to almost all benefits in this Section. In the You pay column, we say "No deductible" when it does not apply. When you receive covered services from network providers either in-network or out-of-network, you are responsible for paying the allowable charges until you meet the deductible. Only CareFirst allowable charges are applicable to the deductible.	100% of allowable charges until you meet the deductible of $1,650 per Self Only enrollment, $3,300 per Self Plus One enrollment and Self and Family enrollment for in-network services and $3,300 per Self Only, and $6,600 per Self Plus One and Self and Family for out-of-network care.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket. Out-of-network: After you meet the deductible, you pay the indicated coinsurance or copayments based on our Plan allowance and any difference between our allowance and the billed amount.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% and is not subject to the calendar year deductible.
- The deductible is $1,650 per Self Only enrollment, $3,300 per Self Plus One and Family enrollment for in-network services. The deductible is $3,300 per Self Only enrollment, or $6,600 per Self Plus One and Family enrollment for out-of-network care.
- Only CareFirst allowable charges are applicable to the deductible.
- The Self and Family deductible can be satisfied by one or more family members.
- The in-network and out of-network deductibles contribute towards one another.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions until you have reached our annual out of pocket maximum.
- When the allowed benefit for any covered service is less than the copayment listed, the member payment will be the allowed benefit.
- Prior authorization is required for all outpatient services performed in the outpatient department of a hospital.
- If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are considered a non-covered service.
- Prior authorization is not required for clinic visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.
- When multiple services are rendered on the same day by more than one provider, member copayments are required for each provider.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and co-pays and coinsurances.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You Pay After the Calendar Year Deductible
Professional Services	
Professional services of physicians: • In physician's office • Inpatient/Skilled nursing Professional (Non-Surgical) • Outpatient Professional (Non-Surgical) • Office medical consultations • Second surgical opinion	**Office/Outpatient Hospital** **In-network:** • PCP - No copay • Specialist - $35 copay **Out-of-network:** • $80 copay Note: Office visits rendered in a hospital, hospital clinic or health care provider's office visit on a hospital campus are not subject to the facility copay. **Inpatient Hospital/Skilled Nursing** **In-network:** • Deductible, then 20% of plan allowance **Out-of-network**: • Deductible, then 30% of plan allowance
Convenience care (Retail health clinic): While primary care providers should be the first line of defense for members, there are tiered care alternatives members can access when their PCP is not available such as CVS MinuteClinic, Walgreens TakeCare and Target Clinic who can serve as the immediate backup to PCPs (after hours).	**In-network:** Deductible, then $0 copay **Out-of-network:** Deductible, then $80 copay
Telehealth Services	
Telemedicine Services: Telemedicine refers to the use of a combination of interactive audio, video, or other electronic media used by a licensed health care provider for the purpose of diagnosis, consultation, or treatment consistent with the provider's scope of practice. Note: Telemedicine must have a video and audio component. Telephone consultations are not a covered service.	Benefits are available to the same extent as benefits provided for other services. Example: - If services are rendered by a PCP, the member would be responsible for the PCP cost- share. -If services are rendered by a Specialist, the member would be responsible for the Specialist cost-share.
CloseKnit, provides virtual only primary care services through a dedicated care team of physicians, nurse practitioners, physician assistants, licensed professional counselors and licensed clinical social workers • Well care / Annual Wellness • Preventative care • Urgent Care • Lifestyle support	**In-network:** deductible, then no copay

Telehealth Services - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Telehealth Services (cont.)	
• Chronic condition prevention and management • Medication management • Clinical educational support • Behavioral Health and mental health support through professional counselors • Care Coordination, including ongoing assistance with care activities such as arranging appointments with specialists, refiling prescriptions, etc.	**In-network:** deductible, then no copay
Diagnostic Services (Professional)	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	**Office/Freestanding Setting** **In-Network:** • Labs: Deductible then, no copay • X-Rays: Deductible then, $35 • Other diagnostic services: Deductible then, $35 **Out-of-Network:** • Labs: Deductible then, 20% of plan allowance • X-Rays: Deductible then, 20% of plan allowance • Other diagnostic services: Deductible then, 20% of plan allowance
Specialty Imaging: • MRA/MRS • MRI • PET • CT/CAT scans	**In-Network:** Deductible then, $75 **Out-of-Network:** Deductible then, 20% of plan allowance
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees. 1. **Preventive Services** a) Preventive outpatient obstetrical care of an uncomplicated pregnancy, including prenatal evaluation and management office visits and one postpartum office visit;	**In-network:** • Preventive - No Charge • Non-Preventive - Deductible, then no charge • Professional Services at Delivery - Deductible, then 20% of plan allowance **Out-of-network:** • Preventive - Deductible, then no charge • Non-Preventive - Deductible, then no charge • Professional Services at Delivery - Deductible, then 30% of plan allowance

Maternity care - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Maternity care (cont.)	
b) Prenatal laboratory tests and diagnostic services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration; c) Preventive laboratory tests and services rendered to a newborn during a covered hospitalization for delivery, identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B", the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, including the collection of adequate samples for hereditary and metabolic newborn screening and newborn hearing screening; and d) Breastfeeding and lactation support, supplies and counseling for each birth Note: Breast pumps are available one per calendar year pre- or post-natal. **2. Non-Preventive Services** a) Outpatient obstetrical care and professional services for all prenatal and post-partum complications, including prenatal and post-partum office visits. Note: Here are some things to keep in mind: • You do not need to pre-certify your vaginal delivery; see page 23 for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment.	**In-network:** • Preventive - No Charge • Non-Preventive - Deductible, then no charge • Professional Services at Delivery - Deductible, then 20% of plan allowance **Out-of-network:** • Preventive - Deductible, then no charge • Non-Preventive - Deductible, then no charge • Professional Services at Delivery - Deductible, then 30% of plan allowance

Maternity care - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Maternity care (cont.)	
• We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits. b) Birthing classes, one course per pregnancy, at a CareFirst BlueChoice approved facility. Note: Members enrolled in the High-Risk OB Care Management Program may be eligible to receive a home blood pressure cuff. **3. Professional Services at Delivery - Professional services are covered under Section 5(a).**	**In-network:** • Preventive - No Charge • Non-Preventive - Deductible, then no charge • Professional Services at Delivery - Deductible, then 20% of plan allowance **Out-of-network:** • Preventive - Deductible, then no charge • Non-Preventive - Deductible, then no charge • Professional Services at Delivery - Deductible, then 30% of plan allowance
Not covered: • Doulas • Surrogacy	*All Charges*
Family planning	
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms • Contraceptive counseling on an annual basis at no cost sharing. Note: See additional Family Planning and Prescription drug coverage 5(f) or 5(f)(a). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below.	**In-network:** • No copay – deductible does not apply **Out-of-network:** • $80 copay

Family planning - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Family planning (cont.)	
Your provider can request authorization by following the steps outlined at www.provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page Urgent requests will be reviewed within 24 hours. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Note: We cover oral contraceptives under the prescription drug benefit	**In-network:** • No copay – deductible does not apply **Out-of-network:** • $80 copay
Voluntary sterilization for a male: Hospital services are covered under Section 5(c). Surgical benefits are covered under Section 5(b).	Deductible applies: **In-network:** • $0 copay **Out-of-network:** • $80 copay
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Elective Abortion*	*All charges*
FDA Approved Fertility Apps	**In-network:** • No copay **Out-of-network:** • No copay
Infertility services	
Diagnosis and treatment of infertility specific to: • Artificial insemination: - Intravaginal Insemination (IVI) - Intracervical Insemination (ICI) - Intrauterine Insemination (IUI) • Fertility drugs see Section 5(f) or 5(f)(a) Note: • We cover drugs for the treatment of infertility, when deemed medically necessary. • When covered for artificial insemination, injectable drugs are medical benefits, and oral drugs are benefits under prescription drug coverage. See Section 5(f). • Prior authorization for the treatment must be obtained from CareFirst BlueChoice.	**In-network:** • $35 office copay **Out-of-network:** • $80 copay

Infertility services - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Infertility services (cont.)	
• Benefits are limited to three (3) attempts per benefit period. • Any charges associated with the collection of the sperm will not be covered unless the partner is also a member. • The member is responsible for the copayment or coinsurance for artificial insemination stated in the Schedule of Benefits. • Coverage is subject to the General Exclusions in Section 6 and the Not Covered section at the end of this Description of Services. • Procedure is covered regardless of whether the couple has a relationship under which the PSHB Program recognizes each partner as a spouse of the other. • Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees. • Infertility is the inability to conceive or produce conception after 1 year of unprotected sex when an individual is under 35 years of age, or 6 months for an individual age 35 or older or failed attempts at artificial insemination. There are various reproductive treatments available for people facing infertility, which are customized according to their medical history and diagnostic results.	**In-network:** • $35 office copay **Out-of-network:** • $80 copay
In vitro fertilization (IVF) IVF involves stimulation of the ovaries with exogenous hormones, retrieval of oocytes/ova (eggs), fertilization of the oocytes in a petri dish, and the transfer of any resulting embryo(s) back into the uterus. Note: • Benefits are limited to three attempts per live birth and limited to $45,000 payment per plan year • Prior authorization for the treatment must be obtained from CareFirst BlueChoice. • IVF benefits are considered if the patient has been unable to attain a successful pregnancy through a less costly infertility treatment under the policy • Infertility is the inability to conceive or produce conception after 1 year of unprotected sex when an individual is under 35 years of age, or 6 months for an individual age 35 or older or failed attempts at artificial insemination. There are various reproductive treatments available for people facing infertility, which are customized according to their medical history and diagnostic results.	**In-network:** • deductible then, 50% coinsurance **Out-of-network:** • deductible then, 50% coinsurance

Infertility services - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Infertility services (cont.)	
• See Section 5(f) or 5(f)(a) for In vitro fertilization (IVF) drugs • Procedure is covered regardless of whether the couple has a relationship under which the PSHB Program recognizes each partner as a spouse of the other. • The in vitro fertilization procedures must be performed at medical facility that conforms to the American College of Obstetricians and Gynecologists (ACOG) guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine (ASRM), (formerly the American Fertility Society) minimal standards for programs of in vitro fertilization. • A completed *Assisted Reproductive Technology Pre-Treatment Form* is required to be submitted for approval, by the Physician. This form may be obtained on the CareFirst website at www.carefirst.com/providers. • Once services are approved, providers will need to obtain separate authorization for infertility medication.	**In-network:** • deductible then, 50% coinsurance **Out-of-network:** • deductible then, 50% coinsurance
Iatrogenic infertility Standard Fertility Preservation for members who have been diagnosed with Iatrogenic Infertility: • the collection of sperm • cryopreservation of sperm • collection of embryo • cryopreservation of embryo • collection of oocyte • cryopreservation of oocyte • benefits limited to up to 12 months of storage of sperm, oocytes and embryo • Fertility drugs see Section 5(f) or 5(f)(a) Prior authorization for the treatment must be obtained from CareFirst BlueChoice. Benefits are limited to three (3) attempts per live birth. If a live birth occurs within the 3 attempts the benefit renews. If the member has 3 failed attempts, the benefit is exhausted for the lifetime of the coverage even if the member switches plans the exhausted benefit does not renew.	**In-network:** • deductible then, $35 office copay **Out-of-network:** • deductible then, $80 copay Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees.
Not covered:	*All charges*

Infertility services - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Infertility services (cont.)	
• *Embryo transfer and gamete intra-fallopian transfer (GIFT)* • *Zygote intra-fallopian transfer (ZIFT)* • *Intrauterine and Assisted reproductive technology (ART) procedures, such as:* - *Services and supplies related to ART procedures* - *Cost of donor sperm* - *Cost of donor egg*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections • Note: If there is a charge for the injection and not the office visit, the office copay will still apply.	**In-network:** • $35 office copay **Out-of-network:** • $80 copay Note: Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees.
Allergy serum	No charge Note: Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees
Treatment therapies	
• Radiation therapy • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary.	**In-network:** • $35 office copay **Out-of network:** • $80 office copay Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.
Infusion Services	
Infusion Services means treatment provided by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion Services also includes enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. Infusion Services includes all medications administered intravenously and/or parenterally.	**In-Network:** Home/Office/Freestanding - Deductible, then $20 copay OP Hospital (attended) - Deductible, then $200 copay **Out-of-network:** Home/Office/Freestanding - Deductible, then $80 copay OP Hospital - Deductible, then $500 copay

Infusion Services - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Infusion Services (cont.)	
Infusion Services: Prior Authorization required for Specialty Drugs • Transfusion services and Infusion Services, including - home infusions, - infusion of therapeutic agents, - medication and nutrients, - enteral nutrition into the gastrointestinal tract, - chemotherapy, and - prescription medications. - Blood and Blood Products (including derivatives and components) that are not replaced by or on behalf of the member Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants	**In-Network:** Home/Office/Freestanding - Deductible, then $20 copay OP Hospital (attended) - Deductible, then $200 copay **Out-of-network:** Home/Office/Freestanding - Deductible, then $80 copay OP Hospital - Deductible, then $500 copay
Physical and occupational and speech therapies	
Up to 60 visits (combined physical, occupational and/or speech therapy) per condition per benefit period for the services of the following qualified providers: • Physical therapists • Occupational therapists • Speech therapists Note: Coverage shall include Physical Therapy, Occupational Therapy and Speech Therapy for the treatment of individuals who have sustained an illness or injury that CareFirst BlueChoice determines to be subject to improvement Note: Occupational Therapy is limited to the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual. Note: Other than any applicable inpatient or outpatient facility copay, member has no copay or coinsurance during an approved inpatient stay. Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.	**In-network:** • $35 office copay **Out-of-network:** • $80 office copay
Not covered: • *Long-term rehabilitative therapy*	*All charges*

Physical and occupational and speech therapies - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Physical and occupational and speech therapies (cont.)	
• *Exercise programs* • *Maintenance therapy*	*All charges*
Cardiac Rehabilitation	
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 90 sessions per condition per benefit period. • Cardiac rehabilitation benefits are provided to members who: - have been diagnosed with a significant cardiac disease - suffered a myocardial infarction - undergone invasive cardiac treatment immediately preceding referral Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.	**In-network:** • $35 office copay **Out-of-network:** • $80 office copay
Not Covered: • *Benefits are not provided for maintenance cardiac rehabilitation.*	*All charges*
Pulmonary Rehabilitation	
Pulmonary Rehabilitation • For those who have significant pulmonary disease or who have undergone certain surgical procedures of the lung. • Limited to one (1) pulmonary rehabilitation program per lifetime. • *Benefits are not provided for maintenance programs* Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient or inpatient facility fees.	**In-network:** • $35 office copay **Out-of-network:** • $80 office copay
Habilitative therapy	
• Habilitative Services are services, including Occupational Therapy, Physical Therapy, and Speech Therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. • Benefits are subject to the applicable Occupational Therapy, Physical Therapy, and Speech Therapy copay but are not counted toward any visit maximum for therapy services.	**In-network:** • Deductible, then $35 office copay **Out-of-network:** • Deductible, then $80 office copay

Habilitative therapy - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Habilitative therapy (cont.)	
• Habilitative Therapy ABA coverage for Applied Behavioral Analysis include Verbal Behavior therapy, Occupation Therapy, Physical Therapy and Speech Therapy from 18 months to 21 years of age. There will be no visit maximums and preauthorization will be required. • Note: Members are responsible for both physician and facility fees. Please refer to section 5(c) for outpatient facility fees	**In-network:** • Deductible, then $35 office copay **Out-of-network:** • Deductible, then $80 office copay
Not covered: • *Benefits delivered through early intervention or school services*	*All charges*
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • Member is responsible for getting approval for all out-of-network services Note: For routine hearing screening performed during a child's preventive care visit, see Section 5 (a), *Preventive care, children.*	**In-network:** • $35 per visit **Out-of-network:** • $80 copay
• **Hearing Aids** - *Medically necessary external hearing aid is covered up to our plan allowance every 36 months.* Note: For medical devices, such as bone anchored hearing aids (BAHA) and cochlear implants, (that or which) are surgically implanted see Orthopedic and prosthetic supplies. For more information on benefits, see Section 5(a) *Orthopedic and prosthetic devices.*	**In-network:** • 25% of Plan Allowance **Out-of-network:** • 25% of Plan Allowance Limited to $3,000 combined in and out of network payment per 36 months. Provider may bill any amount in excess of our plan allowance. Participating providers will advise you in writing in advance if you will have a balance.
Not covered: • *Hearing services that are not shown as covered*	*All charges*

Benefit Description	You Pay After the Calendar Year Deductible
Vision services (testing, treatment, and supplies)	
Medical Vision Services • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions • Medical eye exams Note: This is a medical benefit not a vision benefit.	**In-network:** • Specialist-$35 copay **Out-of-network:** • $80 copay
Routine eye exams Note: See Preventive care, children for eye exams for children Note: Eye care and exams related to medical conditions are subject to the specialist copay	**In-network:** • $10 per visit at Davis Vision Providers **Out-of-network:** • All charges above $33
• *Not covered:* - *Eyeglasses or contact lenses (except as listed above)* - *Eye exercises and orthoptics* - *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses* - *Deluxe eyeglass frames or lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.* - *Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom* - Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of medical conditions as outlined in the CareFirst Medical Policy. - *LASIK, INTACS, radial keratotomy, and other refractive surgery and/or other refractive surgical services* - *Refractions, including those performed during an eye examination related to a specific medical condition*	*All charges*

Benefit Description	You Pay After the Calendar Year Deductible
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	**In-network:** • $35 copay **Out-of-network:** • $80 copay Note: Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Hair Prosthesis (wig) is covered when prescribed by a treating oncologist and the hair loss is the result of chemotherapy. The Plan will cover up to $350 for one (1) hair prosthesis per benefit period. • External hearing aids (See Hearing services in this section for additional information) • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Medically Necessary molded foot orthotics Note: For information on the professional charges for the surgery to insert an implant, see Section 5 (b) *Surgical and anesthesia services.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services*.	**In-network:** • Deductible, then 25% of plan allowance **Out-of-network:** • Deductible, then 25% of plan allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Orthopedic and prosthetic devices (cont.)	
Note: Externally worn prosthetics and devices are treated as Durable medical Equipment (DME)	**In-network:** • Deductible, then 25% of plan allowance **Out-of-network:** • Deductible, then 25% of plan allowance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered* • *Over-the-counter orthotics*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps • Canes • Diabetic shoes • Commodes • Suction machines • Medical supplies (i.e. ostomy and catheter supplies, dialysis supplies, medical foods for inherited metabolic diseases and Inborn Errors of Metabolism (IEM) • Externally worn non-surgical durable devices which replace a body part or assist a patient in performing a bodily function (unless otherwise described in the “orthopedic and prosthetic devices” section above) • Externally worn braces which improve the function of a limb	**In-network:** • Deductible, then 25% of plan allowance Diabetic Supplies- no deductible, 25% of plan allowance up to $100 for a 30-day supply **Out-of-network:** • Deductible, then 25% of plan allowance Diabetic Supplies- no deductible, 25% of plan allowance up to $100 for a 30-day supply

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Durable medical equipment (DME) (cont.)	
• Medically necessary fitted compression stockings Note: Prior authorization is required for certain in-network DME covered services. In-network providers will obtain prior authorization on behalf of the member. See www.provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page for a list of specific Covered Services which require prior authorization	**In-network:** • Deductible, then 25% of plan allowance Diabetic Supplies- no deductible, 25% of plan allowance up to $100 for a 30-day supply **Out-of-network:** • Deductible, then 25% of plan allowance Diabetic Supplies- no deductible, 25% of plan allowance up to $100 for a 30-day supply
Not covered: • *Eye glasses and contact lenses (except as listed under Vision Services)* • *Dental prosthetics (except as listed under Orthopedic and Prosthetics above)* • *Foot orthotics (except as listed under Orthopedic and prosthetic devices)* • *Environment control products* • *Over-the-counter compression stockings* • *Medical equipment of an expendable nature (i.e. ace bandages, incontinent pads)* • *Replacement of DME equipment not due to normal wear and tear* • *Comfort and convenience items* • *Over the counter items, except as listed above* • *Exercise equipment* • *Equipment that can be used for non-medical purposes*	*All charges*
Home health services	
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy. • Home Health Services-Postpartum visits are limited to two (2) per plan year. • Home Health Services-Post Mastectomy/Testicle Removal visits are limited to four (4) per plan year.	**In-network:** • $35 copay **Out-of-network:** • $80 copay
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*

Home health services - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Home health services (cont.)	
• *Private duty nursing*	*All charges*
Chiropractic	
Chiropractic services are limited to spinal manipulation, evaluation and treatment up to a maximum of 20 visits per benefit period when performed by a Plan chiropractor.	**In-network:** • $35 copay **Out-of-network:** • $80 copay Note: Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees.
Not covered: • *Services other than for musculoskeletal conditions of the spine.*	*All charges*
Alternative treatments	
Acupuncture-by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner Limited to 20 visits per Benefit Period.	**In-network:** • $35 copay **Out-of-network:** • $80 copay Note: Members are responsible for both physician and facility fees. Please refer to Section 5(c) for outpatient or inpatient facility fees
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture except as listed above*	*All charges*
Educational classes and programs	
Coverage is provided for: • Tobacco and nicotine cessation programs, including individual/group/phone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to quit smoking (vaping) or other nicotine use.	**In-network:** • No deductible applies • Nothing for counseling for up to two (2) quit attempts per year. • Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. **Out-of-network:** • $80 copay
• Diabetes self-management • Medically necessary nutrition therapy • Medically necessary professional nutritional counseling	**In-network:** • No deductible applies • No copay **Out-of-network:**

Educational classes and programs - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Educational classes and programs (cont.)	
	• $80 copay
Sleep Studies	
CareFirst BlueChoice has created a network of providers that have agreed to oversee this program. The main objective of this approach is diligent monitoring of sleep apnea patients to ensure compliance with their treatment and reducing any further medical complications arising from sleep disorders. CareFirst BlueChoice has also removed the prior authorizations for sleep apnea equipment such as CPAP machines.	**In-Network:** Home - Deductible, then No Charge Office/Freestanding - Deductible, then $35 copay Outpatient Hospital - Deductible, then $200 copay **Out-of-network:** Home - Deductible, then $50 copay Office/Freestanding - Deductible, then $80 copay Outpatient Hospital - Deductible, then $500 copay

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is $1,650 per Self Only enrollment or $3,300 per Self Plus One and Self and Family enrollment for in-network services and $3,300 per Self Only enrollment and $6,600 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Only, Self Plus One, and Self and Family deductible can be satisfied by one(1) or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- Only CareFirst allowable charges are applicable to the deductible.
- After you have satisfied your deductible, your traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- Surgical procedures may involve the services of a co-surgeon, surgical assistant or assistant-at surgery who may bill separately from the primary surgeon.

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You Pay After the Calendar Year Deductible
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery)* • Surgical treatment of severe obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5 (a) *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance

Surgical procedures - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Surgical procedures (cont.)	
Note: You must meet certain criteria to be eligible for bariatric surgery. Please see CareFirst's Medical Policy for the criteria. www.provider.carefirst.com/providers/medical/medical-policy.page Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Foot care)*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see Prosthetic devices)	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Reconstructive surgery (cont.)	
Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance
Gender Affirming Care Services We will cover medically necessary care including where appropriate gender reassignment surgery, hormone therapy, and psychotherapy. Transgender services include, but are not limited to, medical counseling, behavioral health services, hormonal therapy, reconstructive surgery and cosmetic surgery. Please note some cosmetic surgery may be specifically excluded. Prior authorization for transgender services is required. The provider must submit a request for services and clinical information prior to the anticipated date of service through the CareFirst BlueChoice authorization portal or by fax. The clinical information is reviewed for persistent, well-documented gender dysphoria, the capacity to make a fully informed decision and to consent for treatment, age of majority in a given state, documentation to support any significant medical or mental health concerns are reasonably well controlled, and a history of hormone therapy for certain procedures. The request is reviewed according to the member's contract, CareFirst BlueChoice's Operating Procedure for Transgender Services, and CareFirst BlueChoice's Medical Policy for Cosmetic and Reconstructive Surgery. The request is then reviewed by a Medical Director for final determination. The gender reassignment surgeries that may be performed for transwomen (male to female) include but are not limited to: • Orchiectomy: removal of testicles • Penectomy: removal of penis	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Reconstructive surgery (cont.)	
• Vaginoplasty: creation of vagina • Clitoroplasty: creation of clitoris • Labiaplasty: creation of labia • Prostatectomy: removal of prostate • Urethroplasty: creation of urethra • Mammoplasty: breast augmentation The gender reassignment surgeries that may be performed for transmen (female to male) include but are not limited to: • Salpingo-oophorectomy: removal of fallopian tubes and ovaries • Vaginectomy: removal of vagina • Vulvectomy: removal of vulva • Metoidioplasty: creation of micro-penis using the clitoris • Phalloplasty: creation of penis, with or without urethra • Hysterectomy: removal of uterus • Urethroplasty: creation of urethra within penis • Scrotoplasty: creation of scrotum • Testicular prosthesis: implantation of artificial testes • Mastectomy: removal of the breast	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital** • $80 copay

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Oral and maxillofacial surgery (cont.)	
	Inpatient Hospital: • Deductible, then 30% of plan allowance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:**

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Organ/tissue transplants (cont.)	
- Acute myeloid leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic - Hemoglobinopathy - lymphoma (CLL/SLL) - Infantile malignant osteoporosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle Cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Organ/tissue transplants (cont.)	
- Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal nocturnal hemoglobinuria (PNH), Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Organ/tissue transplants (cont.)	
• Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Neuroblastoma	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for:	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Organ/tissue transplants (cont.)	
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance
National Transplant Program (NTP)	**In-network**

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Organ/tissue transplants (cont.)	
• *Note: We cover related medical and hospital expenses of the donor when we cover the recipient.* We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	**In-network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office/Ambulatory Surgical Center (ASC)/Outpatient Hospital** • $80 copay **Inpatient Hospital:** • Deductible, then 30% of plan allowance
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	All charges
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	**In-network** **Office:** • PCP – No copay • Specialist – $35 copay **Ambulatory Surgical Center (ASC):** • PCP – No copay • Specialist – $35 copay **Outpatient Hospital:** • PCP – No copay • Specialist – $35 copay **Inpatient Hospital:** • Deductible, then 20% of plan allowance **Out-of-Network** **Office:** • $80 copay **Ambulatory Surgical Center (ASC):**

Anesthesia - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Anesthesia (cont.)	
	• $80 copay **Outpatient Hospital:** • $80 copay **Inpatient Hospital:** • Deductible, 30% of plan allowance

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $1,650 per Self Only enrollment or $3,300 per Self Plus One and Self and Family enrollment for in-network services and $3,300 per Self Only enrollment and $6,600 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Only, Self Plus One, and Self and Family deductible can be satisfied by one(1) or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- Only CareFirst allowable charges are applicable to the deductible.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts or co-payments for eligible medical expenses and prescriptions until you have reached our annual out of pocket maximum.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5 (c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- Surgical procedures may involve the services of a co-surgeon, surgical assistant or assistant-at surgery who may bill separately from the primary surgeon.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- If a member chooses an out-of-network facility without prior approval, the member will be responsible for any amount in excess of our allowed benefit. If the admission is urgent or a medical emergency, the member will only be responsible for the per admission copay.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate co-pays and coinsurances.

YOUR PHYSICIAN MUST GET PRE-CERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the pre-certification information shown in Section 3 to be sure which services require pre-certification and identify which surgeries require pre-certification.

Benefit Description	You Pay After the Calendar Year Deductible
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	**In-network:** • Deductible, then 20% of plan allowance **Out-of-network:** • Deductible, then 30% of plan allowance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) Note: Hospitalization solely for Acute Rehabilitation is limited to 90 days per benefit period.	**In-network:** • Deductible, then 20% of plan allowance **Out-of-network**: • Deductible, then 30% of plan allowance
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	**In-network:** • Calendar year deductible applies • $100 copay at an ambulatory surgical center • $300 copay in the outpatient department of a hospital for surgical procedures • $200 for non-surgical hospital outpatient and clinic visit **Out-of-network:** • Calendar year deductible applies • $500 copay at an ambulatory surgical center

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay After the Calendar Year Deductible
Outpatient hospital or ambulatory surgical center (cont.)	
Note: Office visits rendered in a hospital, hospital clinic or health care provider's office visit on a hospital campus are not subject to the facility copay	**In-network:** • Calendar year deductible applies • $100 copay at an ambulatory surgical center • $300 copay in the outpatient department of a hospital for surgical procedures • $200 for non-surgical hospital outpatient and clinic visit **Out-of-network:** • Calendar year deductible applies • $500 copay at an ambulatory surgical center • $500 copay in the outpatient department of a hospital and clinic visit
Diagnostic Services such as laboratory tests and pathology services such as: • Non-surgical • Includes but, not limited to EKG's and EEG's • Specialty Imaging	**In-Network:** 1) Labs: Deductible then, $35 2) X-Rays: Deductible then, $50 3) Other diagnostic services: Deductible then, $50 4) Specialty Imaging: Deductible then, $100 **Out-of-Network:** • Deductible, then 30% of plan allowance
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
If a Plan doctor determines that you need full-time skilled nursing care or need to stay in a skilled nursing facility, and we approve that decision, we will cover the comprehensive range of benefits with no dollar or day limit. • Bed, board, and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	**In-Network:** • Facility- 20% of plan allowance **Out of Network:** • Facility- 30% of plan allowance
Not covered: Custodial care	*All charges*

Benefit Description	You Pay After the Calendar Year Deductible
Hospice care	
If terminally ill, you are covered for a supportive and palliative care in your home or at a hospice. This includes inpatient and outpatient care and family counseling. A Plan doctor, who certifies that you are in the terminal stages of illness, with a life expectancy of approximately six (6) months or less, will direct these services. Respite Care is limited to three (3) periods of 48 hours during the Hospice Eligibility Period. Bereavement Services are provided for up to three (3) visits during the 90 days following the patient's death. Note: Hospice services must be pre-approved	**In-network:** • Deductible applies • $35 copay **Out-of-network** • Deductible applies • $80 copay
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate. • Air ambulance, when medically necessary. • The in-network cost-share will now be applied to approved out-of-network air ambulance. Members cannot be balanced billed.	**In-network:** • Calendar year deductible applies • $100 per trip **Out-of-network:** • Calendar year deductible applies • $150 per trip • Non-participating provider may charge you for the amount in excess of our allowed benefit.
Not covered: Air Ambulance unless medically necessary and no other transport is reasonably available.	*All Charges*

Section 5(d). Emergency Services/Accidents

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Benefits are provided for emergency services that you obtain when you have acute symptoms of sufficient severity-including severe pain-such that a prudent layperson who possesses average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in serious jeopardy to the person's health, serious impairment of bodily function, serious dysfunction of any bodily organ or part, or with respect to a pregnant member, serious jeopardy to the health of the member and/or their unborn child.

If you experience a medical emergency, you should call 911 or go directly to the nearest emergency facility. No authorization is needed for you to receive emergency services. Be sure to tell the workers in the emergency room that you are a Plan member so they can notify the Plan.

Urgent Care:

An urgent condition is a condition that is not a threat to your life, limbs, or bodily organs, but does require prompt medical attention. For urgent situations, please call your primary care provider. If your PCP is unavailable, call FirstHelp a free nurse advice line available 24 hours a day, 7 days a week. Call 800-535-9700 to speak to a registered nurse who will discuss your symptoms and recommend the most appropriate care.

Emergencies inside our service area:

You are encouraged to seek care from Plan providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Plan provider, we will provide benefits for the initial treatment provided in the emergency room of the hospital, even if the hospital is not a plan hospital. If you need to stay in a facility our plan does not designate (a non-Plan facility), you must notify the Plan at(800) 367-1799 or (202) 646-0090 within 48 hours or on the first working day after the day they admitted you, unless you cannot reasonably do so. If you stay in a non-Plan facility and a Plan doctor believes that a Plan hospital can give you better care, then the facility will transfer you when medically feasible and we will fully cover any ambulance charges.

For this Plan to cover you, only Plan-providers can give you follow-up care that the non-Plan providers recommend.

Emergencies outside our service area:

- We will provide benefits for any medically necessary health service that you require immediately because of injury or unforeseen illness.
- If you need to stay in a medical facility, you must notify the Plan at (800) 367-1799 or (202) 646-0090 within 48 hours or on the first working day after the date they admit you, unless not reasonably possible to do so. If a Plan doctor believes a Plan hospital can give you better care, then the facility will transfer you when medically feasible, and we will fully cover any ambulance charges.
- For this Plan to cover you, Plan providers must provide any of the follow-up care that non-Plan providers may recommend to you.

Benefit Description	You Pay After the Calendar Year Deductible
Emergency Services	
• Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services *Note: We waive the ER copay if you are admitted to the hospital.* *Note: For services within the service area and provided by a non-participating provider, the member is not responsible for amounts in excess of the allowed benefits.*	**In-network:** • Emergency Room - $300 copay per visit (waived if admitted) • Emergency Room-Professional Services - No copay • Urgent care center - $50 copay per visit **Out-of-network:** • Emergency Room - $300 copay per visit (waived if admitted) • Emergency Room-Professional Services - No copay • Urgent care center - $50 copay per visit Note: Out-of-Network Emergency Room and Professional Services are paid at the In-network level
Not covered: Elective care or non-emergency care	*All charges*
Ambulance	
• Professional ambulance service when medically appropriate. • Air ambulance, when medically necessary. • The in-network cost-share will now be applied to approved out-of-network air ambulance. Members cannot be balanced billed. Note: See 5(c) for non-emergency service.	**In-network:** • Calendar year deductible applies • $100 per trip **Out-of-network:** • Calendar year deductible applies • $150 per trip • Non-participating provider may charge you for the amount in excess of our allowed benefit. Not covered: Air Ambulance unless medically necessary and no other transport is reasonably available.
Not covered: • *Air Ambulance unless medically necessary and no other transport is reasonably available.*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $1,650 per Self Only enrollment or $3,300 per Self Plus One and Self and Family enrollment for in-network services and $3,300 per Self Only enrollment and $6,600 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Only, Self Plus One, and Self and Family deductible can be satisfied by one(1) or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- Only CareFirst allowable charges are applicable to the deductible.
- For facility care, the inpatient deductible applies to almost all benefits in this Section. We added "No deductible" to show when a deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 for more information about precertification.**
- We will provide medical review criteria or reason for treatment plan denial to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- Members will be responsible for all costs between the plan allowance and provider billed charges.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate co-pays and coinsurances.

Note: Inpatient professional services are paid the same as medical inpatient professional services.

Benefits Description	You Pay After the Calendar Year Deductible
Professional services	**HDHP**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment	**In-network:** • Inpatient professional - Deductible, then 20% of plan allowance • Office - No copay • Outpatient Professional Services- $35 copay **Out-of-network:** • Inpatient professional - Deductible, then 30% of plan allowance • Office/Outpatient Professional Services - $80 copay

Professional services - continued on next page

Benefits Description	You Pay After the Calendar Year Deductible
Professional services (cont.)	**HDHP**
• Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting	**In-network:** • Inpatient professional - Deductible, then 20% of plan allowance • Office - No copay • Outpatient Professional Services- $35 copay **Out-of-network:** • Inpatient professional - Deductible, then 30% of plan allowance • Office/Outpatient Professional Services - $80 copay
Inpatient hospital or other covered facility	**HDHP**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	**In-network:** • Deductible, then 20% of plan allowance **Out-of-network:** • Deductible, then 30% of plan allowance
Outpatient hospital or other covered facility	**HDHP**
• Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment Note: Prior authorization is not required for administration of prescription drugs used to treat an opioid use disorder which contain methadone, buprenorphine, or naltrexone, when rendered in the Outpatient Mental Health and Substance Abuse setting	**In-network:** • Calendar year deductible applies • $100 for non-surgical hospital outpatient admissions **Out-of-network:** • Calendar year deductible applies • $150 copay in the outpatient department of a hospital
Not covered	**HDHP**
• Services that are not part of a preauthorized approved treatment plan.	*All charges*
CareFirst Addiction Program	**HDHP**
The goals of the Alcohol and Drug Addiction Community-Based Program are to: 1. Provide Members with necessary treatments to deliver the best outcomes for their individual clinical circumstances. 2. Provide access to cost effective addiction treatment programs that offer the most up-to-date clinically appropriate standards. 3. Educate Members, PCPs and all stakeholders as to the causes, identification and treatments of addiction.	• **CareFirst Preferred Addiction Recovery center** - No cost share for intensive outpatient treatment program • **Other outpatient recovery centers** - standard out-of-pocket amounts (copay, deductible, coinsurance) will apply.

CareFirst Addiction Program - continued on next page

Benefits Description	You Pay After the Calendar Year Deductible
CareFirst Addiction Program (cont.)	**HDHP**
4. Provide appropriate care in a community setting outside of a hospital or residential setting to enhance sustainable outcomes and lower costs. Members may receive any of the following services as part of their treatment: • Assessment • Intensive outpatient program • Outpatient detox • Partial hospital program (PHP) • Individual therapy • Group therapy • Family therapy • Medication assisted treatment (MAT) (includes psychiatrist assessment) Preferred Recovery Centers can be located at https://member.carefirst.com/members/health-wellness/staying-healthy/addiction-program.page	• **CareFirst Preferred Addiction Recovery center** - No cost share for intensive outpatient treatment program • **Other outpatient recovery centers** - standard out-of-pocket amounts (copay, deductible, coinsurance) will apply.

Section 5(f). Prescription Drug Benefits

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their prescriber obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- The calendar year deductible is $1,650 per Self Only enrollment or $3,300 per Self Plus One and Self and Family enrollment for in-network services and $3,300 per Self Only enrollment and $6,600 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one (1) or more family members. The deductible applies to all benefits in this section unless we indicate differently.
- Only CareFirst allowable charges are applicable to the deductible.
- After you have satisfied your deductible, your traditional medical coverage begins.
- The deductible is waived for preferred generic drugs to treat asthma, blood pressure, cholesterol, depression and diabetes.
- Under your traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- Mandatory Generic Drug Substitution applies to this plan. If your physician writes "Dispense as Written" for the brand-name drug, and you receive a brand-name drug when a Federally approved generic drug is available, you will have to pay the difference in cost between the brand-name drug and the generic plus the brand copay.
- Out-of-Network: Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies.

Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription**. A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them**. You may fill the prescription at a Plan pharmacy, or by mail. You may contact **CVS Health** at **(800) 241-3371** to get more information on the mail order service. We will now require members to fill certain specialty medications within a designated network. Currently the exclusive specialty pharmacy network consists of **CVS/ Caremark**.
- **We use a formulary**. A formulary is a list of covered drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other heatlh care professionals who make sure the drugs on the formulary are safe and clinically effective. Some drugs may be excluded from the formulary and others may require prior authorization from the plan before being filled. Members may request a medical necessity waiver from the plan to obtain medications that require prior authorization or medications that are excluded from formulary.
- **We have a managed formulary**. If your provider believes a name brand product is necessary or there is no generic available, a name brand drug from a formulary list may be prescribed. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, you may contact **CVS Health** at **(800)241-3371**.

- **These are the dispensing limitations.** You can receive up to 34 days' worth of medication for each fill of prescriptions at a local Plan pharmacy. In addition, you can receive up to 90 days of medications through our mail order pharmacy program or through a local pharmacy, and will pay two (2) copays. Your copay will be $0, $50, $75 or $150 for a 34-day supply or less at the retail pharmacy and twice that amount for 35-day supply or greater up to 90 days. You can purchase the same prescriptions through the mail order service that can be purchased through your community pharmacy. In most cases, you can get a refill once you have taken 75% of the medication. Your prescription will not be refilled prior to the 75% usage guidelines. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Certain drugs require clinical prior authorization. Contact the Plan for a listing of which drugs are subject to the prior authorization policy. Prior authorization may be initiated by the Prescriber or the pharmacy by calling **CVS Health** at **(800)241-3371**.
- **Why use generic drugs.** A generic drug is the chemical equivalent of a corresponding brand name drug dispensed at a lower cost. You can reduce your out-of-pocket expenses by choosing a generic drug over a brand name drug. Please check the detailed charts in this section to see what you would pay should you get the brand named drug when a generic equivalent is available. If a drug is not available in a generic form, the appropriate brand copay will apply. Mandatory Generic Drug Substitution applies to this plan. If your physician writes "Dispense as Written" for the brand name drug, and you receive a brand name drug when a Federally approved generic drug is available, you will have to pay the difference in cost between the brand name drug and the generic plus the brand copay.
- **When you do have to file a claim**. Call our preferred drug vendor, **CVS Health** at **(800)241-3371** to order prescription drug claim forms. You will send the prescription drug claim form to: **CVS Health**, **P.O. Box 52136, Phoenix, AZ 85072**.
- **Specialty drugs are covered** exclusively through CVS Specialty. Specialty drugs are high-cost, prescription drugs used to treat serious or chronic medical conditions and require special handling (such as refrigeration), administration or monitoring. Through CVS Specialty, you will receive convenient mail delivery to the address of your choice including your home, doctor's office or a CVS Pharmacy location. CVS Specialty provides your specialty drugs and personalized pharmacy care management services including:
  - Access to a team of clinicians specially trained in your condition
  - On-call pharmacist 24 hours a day, seven days a week
  - Coordination of care with you and your doctor
  - Drug and condition-specific education and counseling
  - Insurance and financial coordination assistance
- **Your doctor may send a prescription to CVS Specialty via e-prescription, phone (800-799-0692), or fax (855-296-0210).**

Benefits Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to: Disposable needles and syringes for administration of covered medications. • Drugs for sexual dysfunction (Subject to dosage limitations) • Drugs to treat gender dysphoria - The following drug classes are typically used for gender dysphoria and are covered regardless of gender designation:	Retail up to 34-day supply per copay: Select Generics - No deductible and $0 Tier 1 generics - Deductible, then $0 Tier 2 preferred brand - Deductible, then $50 Tier 3 non-preferred brand - Deductible, then $75 Tier 4 preferred specialty - Deductible, then $100 Tier 5 non-preferred specialty - Deductible, then $150 Preferred and non-preferred brand Insulin - No deductible, then $30 copay Opioid Reversal Agents- Deductible, then $0

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	
• Progestins • Gonadotropin-Releasing Hormone Agonists • Aldosterone Antagonists, Selective • Antineoplastics, Antiandrogens • Oral Contraceptives • Estrogen Derivatives • Androgens • Drugs for anti-obesity based on medical necessity and require prior authorization • IVF drugs based on medical necessity and require prior authorization Note: Infertility is the inability to conceive or produce conception after 1 year of unprotected sex when an individual is under 35 years of age, or 6 months for an individual age 35 or older or failed attempts at artificial insemination. There are various reproductive treatments available for people facing infertility, which are customized according to their medical history and diagnostic results. Note: • Specialty drugs are typically high in cost and have one or more of the following characteristics: - Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology - Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects - Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy - Unique patient compliance and safety monitoring requirements - Unique requirements for handling, shipping, and storage - Intravenous fluids and medications for home use, implantable drugs (such as Norplant), some injectable drugs (such as Depo Provera), and IUDs are covered under the Medical and Surgical Benefits - Specialty drugs require pre-authorization and the use of preferred pharmacies - Glucometers are covered as Durable Medical Equipment under the Medical and Surgical Benefits. See page xxx	Retail up to 34-day supply per copay: Select Generics - No deductible and $0 Tier 1 generics - Deductible, then $0 Tier 2 preferred brand - Deductible, then $50 Tier 3 non-preferred brand - Deductible, then $75 Tier 4 preferred specialty - Deductible, then $100 Tier 5 non-preferred specialty - Deductible, then $150 Preferred and non-preferred brand Insulin - No deductible, then $30 copay Opioid Reversal Agents- Deductible, then $0 Maintenance Drugs up to 90-day supply per copay: Select Generics - No deductible and $0 Tier 1 generics - Deductible, then $0 Tier 2 preferred brand - Deductible, then $100 Tier 3 non-preferred brand - Deductible, then $150 Tier 4 preferred specialty - Deductible, then $200 Tier 5 non-preferred specialty - Deductible, then $300 Mandatory Generic Drug Substitution applies to this plan. If your prescriber writes "Dispense as Written" for the brand name drug, and you receive a brand name drug when a Federally approved generic drug is available, you will have to pay the difference in cost between the brand name drug and the generic plus the brand copay.

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	
- No deductible for select generic drugs for treatment of asthma, blood pressure, cholesterol, depression and diabetes - Specialty drugs are limited to a 34-day supply for the first initial fill	Retail up to 34-day supply per copay: Select Generics - No deductible and $0 Tier 1 generics - Deductible, then $0 Tier 2 preferred brand - Deductible, then $50 Tier 3 non-preferred brand - Deductible, then $75 Tier 4 preferred specialty - Deductible, then $100 Tier 5 non-preferred specialty - Deductible, then $150 Preferred and non-preferred brand Insulin - No deductible, then $30 copay Opioid Reversal Agents- Deductible, then $0 Maintenance Drugs up to 90-day supply per copay: Select Generics - No deductible and $0 Tier 1 generics - Deductible, then $0 Tier 2 preferred brand - Deductible, then $100 Tier 3 non-preferred brand - Deductible, then $150 Tier 4 preferred specialty - Deductible, then $200 Tier 5 non-preferred specialty - Deductible, then $300 Mandatory Generic Drug Substitution applies to this plan. If your prescriber writes "Dispense as Written" for the brand name drug, and you receive a brand name drug when a Federally approved generic drug is available, you will have to pay the difference in cost between the brand name drug and the generic plus the brand copay.
The following prescription drugs are covered in full: - Chemotherapy medications received through a pharmacy - Preventive breast cancer drugs for women who are at an increased risk for breast cancer, and at a low risk for adverse medication effects Please refer to our website www.carefirst.com/pshbp for any updates to this list and for additional information on how these items are covered.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below.	No copay

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	
• Preventive Services Contraceptive Zero Copay Exception criteria is intended to allow the member to receive a $0 member cost share for any Health Care Reform preventive services contraceptive product not already covered at a $0 member cost share when determined to be medically necessary. To request the exception your provider should contact CVS directly via phone or fax the Exception Request Form. A response will be provided within 24hrs of receiving the completed Exception Request Form. • If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a)	No copay
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except as listed above* • *Nonprescription medications unless specifically indicated elsewhere* • Fertility drugs that are not deemed medically necessary. Note: Drugs that do not require a prescription by Federal law (Over-the-counter medications) that are not part of the preventive drug benefit. Listed preventive care over-the-counter drugs can be submitted only if the member presents a prescription form completed by an authorized provider.	*All Charges*
Preventive medications	
The following are covered: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.

Preventive medications - continued on next page

Benefits Description	You pay
Preventive medications (cont.)	
Preventive Care medications to promote better health as recommended by ACA includes the following: • Men and women ages 40 through 75 years old • No quantity limit • No prior authorization • Low to moderate dose statins, generics only (no high dose or brand statins are included) The following generic drugs are covered without cost-share as prescribed by a health care professional and filled at a network pharmacy and will be made available as follows: • Atorvastatin 10 mg, 20 mg • Fluvastatin 20 mg, 40 mg • Fluvastatin ER 80 mg • Lovastatin 10 mg, 20 mg, 40 mg • Pravastatin 10 mg, 20 mg, 40 mg, 80 mg • Rosuvastatin 5 mg, 10 mg • Simvastatin 5 mg, 10 mg, 20 mg, 40 mg Note: For statin prescriptions outside of these age ranges and/or strengths our standard plan benefits will apply.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Smoking deterrents Note: Medications approved by the FDA to treat tobacco dependence are covered under the tobacco and nicotine cessation benefits and dispensed under our pharmacy program. To be covered, the medications must be prescribed by a physician, even if it is available over-the-counter.	No charge, up to two (2) attempts per year.
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/.	Deductible, then $0 copay
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics*	*All charges*

Preventive medications - continued on next page

Benefits Description	You pay
Preventive medications (cont.)	
• *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except as listed above* • *Nonprescription medications unless specifically indicated elsewhere* • Fertility drugs that are not deemed medically necessary. Note: Drugs that do not require a prescription by Federal law (Over-the-counter medications) that are not part of the preventive drug benefit. Listed preventive care over-the-counter drugs can be submitted only if the member presents a prescription form completed by an authorized provider.	*All charges*

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at (833) 489-1316.
- The plan name for your PDP EGWP coverage is CareFirst BlueCross BlueShield Group Medicare Rx (PDP).

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- Your plan offers coverage for prescription drugs on a Medicare formulary (drug list). This is considered the Primary / Medicare Prescription Drug Coverage. If your drug is not covered on the Medicare formulary, your plan offers secondary coverage as well. The plan includes additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan.

We cover drugs, medications, and supplies as described below and on the following pages.

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused drugs, medications, and supplies.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.
- Use a network pharmacy
- You will enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.
- Out-of-Network: Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies

- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage.
- If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at (833) 489-1316.

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at (833) 489-1316.

Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, and a mail order form will be accessible at www.carefirst.com/pshbp. You can also obtain a copy of the Evidence of Coverage for your CareFirst BlueCross BlueShield Group Medicare Rx (PDP) plan at www.carefirst.com/pshbp.

There are important features you should be aware of. **These include:**

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You may fill prescriptions at any network pharmacy. For assistance locating a PDP EGWP network pharmacy, visit our website at www.carefirst.com/pshbp, or call us at (833) 840-7962.
- **We have a managed formulary.** Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. You may view our formulary on our website at www.carefirst.com/pshbp or call us at (833) 840-7962.
- **These are the dispensing limitations** You can receive up to 30 days' worth of medication for each fill of prescriptions at a local Plan pharmacy. In addition, you can receive up to 90 days of medications through our mail order pharmacy program or through a local pharmacy, and will pay two (2) copays. In most cases, you can get a refill once you have taken 75% of the medication. Your prescription will not be refilled prior to the 75% usage guidelines. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Contact the Plan for a listing of which drugs are subject to the prior authorization policy. Prior authorization may be initiated by the Prescriber or the pharmacy by calling **CVS Health** at **(833) 840-7962**.
- **We may require** Utilization Management strategies. Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:
  - **Prior Authorization:** CareFirst BlueCross BlueShield Group Medicare Rx (PDP) requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from CareFirst BlueCross BlueShield Group Medicare Rx (PDP) before you fill your prescriptions. If you don't get approval, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) may not cover the drug.
  - **Quantity Limits:** For certain drugs, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) limits the amount of the drug that CareFirst BlueCross BlueShield Group Medicare Rx (PDP) will cover.
  - **Step Therapy:** In some cases, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) may not cover Drug B unless you try Drug A first. If Drug A does not work for you, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) will then cover Drug B.
- **You may request a Formulary Exception.** You can ask CareFirst BlueCross BlueShield Group Medicare Rx (PDP) to make an exception to our coverage rules.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.
- You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.Generally, CareFirst BlueCross BlueShield Group Medicare Rx (PDP) will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

  You or your prescriber should contact us to ask for a tiering or, formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

  How to Request a Coverage Determination

  A member, prescriber, or a member's appointed representative may request a standard or expedited coverage determination. You, your prescriber or your appointed representative may request a coverage decision and/or exception any of the following ways:

  Phone:

  Contact customer service for any requests including making an oral request related to Coverage Determination and Appeals. Our customer service team is available 24/7/365 at 833-840-7962. Appeals calls are then redirected to the correct department for further action. Other means of contact are provided below.

  Fax: 855-633-7673

  Online: Coverage Determination Form

  Mail:

  CVS Caremark Coverage Determinations/Exceptions
  P.O. Box 52000
  Phoenix, AZ 85072-2000

- **Why use generic drugs.** A generic drug is the chemical equivalent of a corresponding brand name drug dispensed at a lower cost. You can reduce your out-of-pocket expenses by choosing a generic drug over a brand name drug. Please check the detailed charts in this section to see what you would pay should you get the brand named drug when a generic equivalent is available. If a drug is not available in a generic form, the appropriate brand copay will apply.
- **When you do have to file a claim.** Call our preferred drug vendor, **CVS Health** at **(833) 840-7962** to order prescription drug claim forms. You will send the prescription drug claim form to: **CVS Health**, **P.O. Box 52136, Phoenix, AZ 85072.**
- **If we deny your claim and you want to appeal**, you, your representative, or your prescriber must request an appeal following the process described in Section 8(a). Medicare PDP EGWP Disputed Claims Process. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

- **Specialty drugs are covered** exclusively through CVS Specialty. Specialty drugs are high-cost, prescription drugs used to treat serious or chronic medical conditions and require special handling (such as refrigeration), administration or monitoring. Through CVS Specialty, you will receive convenient mail delivery to the address of your choice including your home, doctor's office or a CVS Pharmacy location. CVS Specialty provides your specialty drugs and personalized pharmacy care management services including:
  - Access to a team of clinicians specially trained in your condition
  - On-call pharmacist 24 hours a day, seven days a week
  - Coordination of care with you and your doctor
  - Drug and condition-specific education and counseling
  - Insurance and financial coordination assistance

PDP EGWP Catastrophic Maximum

The PDP EGWP Catastrophic Maximum of $2,000 is the most you would need to spend each year on medications covered by your plan before you reach the Catastrophic Coverage Stage. The amounts you spend on your primary and secondary prescription drug benefits count toward this maximum. These amounts will also count towards your Maximum Out of Pocket (also known as Catastrophic Protection Out of Pocket Maximum).

Benefits Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • **Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*** • **Insulin** • **Diabetic supplies limited to: Disposable needles and syringes for the administration of covered medications** • **Drugs for sexual dysfunction** • **Drugs to treat gender dysphoria** - **The following drug classes are typically used for gender dysphoria and are covered regardless of gender designation:** • **Drugs for anti-obesity based on medical necessity and require prior authorization** • **IVF drugs based on medical necessity and require prior authorization**	Your plan offers coverage for prescription drugs on a Medicare formulary (drug list). This is considered your Primary / Medicare Prescription Drug Coverage. If your drug is not covered on the Medicare formulary, your plan offers secondary coverage as well. Your plan includes additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. Search this plan's Medicare Part D formulary. If your prescription drug is not covered on the Medicare formulary, you will need to check the CareFirst Prescription Formulary 2 for your drug. The formulary files can be found at www.carefirst.com/pshbp. If the drug is covered under both formularies your will pay the lesser of the applicable cost share listed below. **Medicare Part D Prescription Drug Benefits:** Retail: up to 30-day supply per copay: • Tier 1: Preferred Generic: $0 copay • Tier 2: Generic: $0 copay • Tier 3: Preferred Brand: $50 copay • Tier 4: Non-Preferred Drug: $75 copay • Tier 5: Specialty Tier: $100 copay Maintenance Drugs Up to 90-day supply per copayment: • Tier 1: Preferred Generic: $0 copay • Tier 2: Generic: $0 copay • Tier 3: Preferred Brand: $100 copay • Tier 4: Non-Preferred Drug: $150 copay • Tier 5: Specialty Tier: Not Covered

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	
Note: Infertility is the inability to conceive or produce conception after 1 year of unprotected sex when an individual is under 35 years of age, or 6 months for an individual age 35 or older or failed attempts at artificial insemination. There are various reproductive treatments available for people facing infertility, which are customized according to their medical history and diagnostic results. **Note: Specialty Drugs are typically high in cost and have one or more of the following characteristics:** • **Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology** • **Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects** • **Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy** • **Unique patient compliance and safety monitoring requirements** • **Unique requirements for handling, shipping, and storage** • **Intravenous fluids and medications for home use, implantable drugs (such as Norplant), some injectable drugs (such as Depo Provera), and IUDs are covered under the Medical and Surgical Benefits** • **Specialty drugs require pre-authorization and the use of preferred pharmacies** • **Glucometers are covered as Durable Medical Equipment under the Medical and Surgical Benefits.** • **Specialty drugs are limited to a 34-day supply for the first initial fill**	Your plan offers coverage for prescription drugs on a Medicare formulary (drug list). This is considered your Primary / Medicare Prescription Drug Coverage. If your drug is not covered on the Medicare formulary, your plan offers secondary coverage as well. Your plan includes additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. Search this plan's Medicare Part D formulary. If your prescription drug is not covered on the Medicare formulary, you will need to check the CareFirst Prescription Formulary 2 for your drug. The formulary files can be found at www.carefirst.com/pshbp. If the drug is covered under both formularies your will pay the lesser of the applicable cost share listed below. **Medicare Part D Prescription Drug Benefits:** Retail: up to 30-day supply per copay: • Tier 1: Preferred Generic: $0 copay • Tier 2: Generic: $0 copay • Tier 3: Preferred Brand: $50 copay • Tier 4: Non-Preferred Drug: $75 copay • Tier 5: Specialty Tier: $100 copay Maintenance Drugs Up to 90-day supply per copayment: • Tier 1: Preferred Generic: $0 copay • Tier 2: Generic: $0 copay • Tier 3: Preferred Brand: $100 copay • Tier 4: Non-Preferred Drug: $150 copay • Tier 5: Specialty Tier: Not Covered Note: Under the Medicare Part D Prescription Drug Benefits if a prescriber writes "Dispense as Written" for the brand name drug, and the member receives a brand name drug when a Federally approved generic drug is available, the member will just pay the brand copay. **Secondary Coverage: HDHP Formulary 2 Prescription Benefits** Retail up to 34-day supply per copay: Select Generics - $0 copay Tier 1 generics - $0 copay Tier 2 preferred brand - $50 copay Tier 3 non-preferred brand - $75 copay Tier 4 preferred specialty - $100 copay Tier 5 non-preferred specialty - $150 copay Preferred and non-preferred brand Insulin - No deductible, then $30 copay Opioid Reversal Agents- $0 copay

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	
	Maintenance Drugs up to 90-day supply per copay: Select Generics - $0 copay Tier 1 generics - $0 copay Tier 2 preferred brand - $100 copay Tier 3 non-preferred brand - $150 copay Tier 4 preferred specialty - $200 copay Tier 5 non-preferred specialty - $300 copay Mandatory Generic Drug Substitution applies to the HDHP Formulary 2 Prescription Benefits. If your prescriber writes "Dispense as Written" for the brand name drug, and you receive a brand name drug when a Federally approved generic drug is available, you will have to pay the difference in cost between the brand name drug and the generic plus the brand copay.
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Preventive Services Contraceptive Zero Copay Exception criteria is intended to allow the member to receive a $0 member cost share for any Health Care Reform preventive services contraceptive product not already covered at a $0 member cost share when determined to be medically necessary. To request the exception your provider should contact CVS directly via phone or fax the Exception Request Form. A response will be provided within 24hrs of receiving the completed Exception Request Form. • If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a)	$0 copay
The following prescription drugs are covered in full:	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	
- Chemotherapy medications received through a pharmacy - Preventive breast cancer drugs for women who are at an increased risk for breast cancer, and at a low risk for adverse medication effects Please refer to our websitewww.carefirst.com/pshbp for any updates to this list and for additional information on how these items are covered.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out of area emergencies* • *Nonprescription medications medicines*	*All charges*
Preventive medications	
The following are covered: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Preventive Care medications to promote better health as recommended by ACA includes the following: • Men and women ages 40 through 75 years old • No quantity limit • No prior authorization • Low to moderate dose statins, generics only (no high dose or brand statins are included) The following generic drugs are covered without cost-share as prescribed by a health care professional and filled at a network pharmacy and will be made available as follows: • Atorvastatin 10 mg, 20 mg • Fluvastatin 20 mg, 40 mg • Fluvastatin ER 80 mg • Lovastatin 10 mg, 20 mg, 40 mg • Pravastatin 10 mg, 20 mg, 40 mg, 80 mg • Rosuvastatin 5 mg, 10 mg • Simvastatin 5 mg, 10 mg, 20 mg, 40 mg	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.

Preventive medications - continued on next page

Benefits Description	You pay
Preventive medications (cont.)	
Note: For statin prescriptions outside of these age ranges and/or strengths our standard plan benefits will apply.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Smoking deterrents Note: Medications approved by the FDA to treat tobacco dependence are covered under the tobacco cessation benefits and dispensed under our pharmacy program. To be covered, the medications must be prescribed by a physician, even if it is available over-the-counter	Nothing, up to two (2) attempts per year
Opioid rescue agents such as naloxone are covered under this Plan with no copay when obtained from a plan pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www.findtreatment.samhsa.gov/	$0 copay
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Please remember that, when you see providers who are not contracted with CareFirst BlueCross BlueShield or are not participating in any of our networks, you may be responsible for any amount in excess of our allowed benefit in addition to the appropriate deductible and copay.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefits Description	You pay after the calendar year deductible
Accidental injury benefit	**HDHP**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	**In-network:** • $35 visit copay **Out-of-network:** • $80 visit copay
Dental benefits	**HDHP**
We have no other dental benefits	*All charges*

Section 5(h). Wellness and Other Special Features

Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hour nurse line	If you have any health concerns, call FirstHelp at (800) 535-9700, 24 hours a day, 7 days a week and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	Our TTY number for Customer Service is (202) 479-3546.
Care Team Program	We provide programs for members diagnosed with coronary artery disease, congestive heart failure, diabetes, cancer, asthma and other chronic conditions. These programs are designed to help you better understand and manage your condition. Our Care Team Program benefits may include: • Educational materials, such as self-monitoring charts, resource listings, self-care tips, and a quarterly newsletter • A health assessment and nurse consultation • Access to a 24-hour Nurse Advisor help line Please call us at (800) 783-4582 for more information about our Care Team Program.
Guest membership	If you, or one of your covered family members, move outside of our service area for an extended period of time (for example, if your child goes to college in another state), you may be able to take advantage of our Guest Membership Program. This program may allow you or your dependents the option to utilize the benefits of an affiliated BlueCross BlueShield HMO. Please contact us at (888) 452-6403 for more information on the Guest Membership Program.

Blue Rewards	Financial incentives can effectively encourage Members to take an active role in their own health. Through Blue Rewards - the CareFirst Health and Wellness Incentive Program - Members can earn a reward for completing specific activities that increase the likelihood of success in their wellness efforts. The Blue Rewards incentive program will include Subscribers and Spouse/ Domestic Partners for all CareFirst medical plans to encourage initial and ongoing engagement. Blue Rewards will feature three types of rewards 1) participation-based rewards, 2) ongoing rewards, and 3) coaching rewards: Both you and your spouse/domestic partner will be rewarded for completing one, or all of the following activities: 1. Choose a PCP AND complete their health screening with your PCP or at a CVS MinuteClinic to earn $100. You must complete within 180 days of your effective date. 2. Complete a health assessment AND provide consent to receive wellness related communications (emails) to earn $50. You must complete within 180 days of your effective date. 3. Retake by updating/confirming responses to your health assessment. Answers must be updated or confirmed no earlier than 90 days after the original assessment, and before the end of the benefit period to earn $50. 4. Participate in Health Coaching Sessions. You may earn rewards for completing one (1), two (2), or three (3) coaching sessions. Completing coaching sessions are based on member participation and not dependent on achieving an outcome and/or health- related goal. Only one (1) coaching session per 2-60 days will count towards an incentive. Members will earn $30 for coaching session one, $70 for coaching session two, and $100 for coaching session three. A maximum of three (3) coaching sessions per Benefit Period will count towards the incentive. Members will receive their incentive in the form of a medical expense debit card to help pay for deductibles, copays, and coinsurance for CareFirst health, pharmacy, vision, and dental costs. If you are enrolled in a medical health plan with a health savings account (HSA), you will need to meet your IRS minimum deductible before using the Blue Rewards medical incentive debit card. If you have CareFirst vision or dental benefits, you can certify to only use the card for eligible vision/dental expenses prior to meeting their deductible. The debit card reduces barriers to care and is preloaded with Merchant Category Codes (MCC) for eligible medical expenses that dictate whether the card will work at a specific location. If the member tries to use the card at a location where the MCC is not loaded, the card will reject the charge. To get started, visit carefirst.com/wellbeing. You'll need to complete the one-time registration to link your CareFirst account information. This will help personalize your experience.

SmartShopper Program	The SmartShopper incentive and engagement Program is available to Subscribers and Spouses for all CareFirst medical plans. A Member is eligible to participate in the program if they require a specific treatment or procedure as specified by CareFirst. A Member is able to utilize the SmartShopper Program by means of CareFirst's integrated digital tool or by calling 888-345-2873 and speaking with a member of the Personal Assistant Team ("PAT"). Members are able to earn rewards for selecting the most cost-effective providers and site of service for care. A Member will receive an incentive for each service or category of Comparable Health Care Service resulting from comparison shopping and there is no limit on the Incentive amount(s) a member may earn in the benefit period. Members will receive their incentive in the form of a medical expense debit card to help pay for deductibles, copays, and coinsurance for CareFirst health, pharmacy, vision, and dental costs. Members who choose the high-deductible health plan option, and choose to fund their account, are not allowed to use their card funds for eligible medical and/or prescription expenses until first satisfying their IRS minimum deductible. However, these members can use the card funds for eligible dental and or vision expenses that are part of the benefit plan.
Ovia Health	Included with your CareFirst WellBeing program for members 18 and over, Ovia offers support for reproductive health, including conceiving, pregnancy, post-partum, parenting, and perimenopause/ menopause. Users will choose their goal and Ovia will customize the member experience to deliver personalized insights, tips and content - which includes access to Care Advocates and coaches specializing in reproductive health. Follow these steps to get started today! 1. Log in to your CareFirst WellBeing account (or create one at carefirst.com/wellbeing) 2. Under Achieve, choose Programs to view your women's health programs 3. Select Ovia and follow the prompts to get started 4. Download the Ovia app and explore

Section 5(i). Health Education Resources and Account Management Tools

Special features	Description
Health education resources www.carefirst.com/pshbp Visit our expanded web option	***My Account*** This tool gives members access to their claims and benefit eligibility information when they log in to the secure, password- protected site. Each covered member over the age of 14 may create their own user ID and password. After creating a password, members can: • View who is covered under their contract • Current and historical claims status • Order a new ID card Additional features include: • Drug pricing tool • Hospital comparison tool • Treatment cost estimator • Provider Directory with special information • Health Risk Assessment ***My CareFirst*** This is our member health and wellness section. Here you can find: • Health Library of Medical Conditions • Health Lifestyle Section: Nutrition, Fitness, etc. • Personal Health page, with tracking tools and assistance setting health and wellness goals ***Telephonic Health Coaching*** The healthy lifestyle coaching program fills a void between healthy employees and those who suffer from chronic diseases. Employees who are at high risk for future disease as identified by MyHealthProfile are invited to participate in healthy lifestyle coaching sessions. • These are scheduled phone conversations where employees develop a relationship with a clinician (health coach) trained in motivational interviewing and in behavior change theory. The health coach identifies a number of factors including the employee's existing barriers to change and their readiness to change. The health coach then helps the employee set achievable short-term and long-term goals so they can make a permanent change in health behavior.
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through www.carefirst.com/pshbp Your balance will also be shown on your explanation of benefits (EOB) form. You will receive an EOB after every claim. If you have an **HSA**: • Once your account is activated, periodic accounts statements will be available • To receive electronic statements: - Log on on to www.carefirst.com/pshbp to complete initial registration and gain entry to "My Account"

	• You may also access your account on-line at www.carefirst.com/pshbp If you have an HRA: • Your balance will also be shown on your EOB form. • Log on on to www.carefirst.com/pshbp • Your HRA balance will be available online after you login through www.carefirst.com/pshbp then click on "Coverage" and under "My Plan" click on "BlueFund HRA."
Consumer choice information	As a member of BlueChoice Advantage HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.carefirst.com/pshbp. Pricing information for medical care and prescription drugs is available at www.carefirst.com/pshbp. Link to online pharmacy through www.carefirst.com/pshbp. Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.carefirst.com/pshbp
Care support	Patient safety information is available online at www.carefirst.com/pshbp.

Non-PSHB Benefits Available to Plan Members

The benefits on this page are not part of the PSHB contract or premium, and you cannot file an PSHB disputed claim about them. Fees you pay for these services do not count toward PSHB deductibles or out-of-pocket maximums. These programs and materials are the responsibility of the Plan and all appeals must follow their guidelines. For additional information, contact the Plan at (833)-489-1316 or visit their website at www.carefirst.com/pshbp

Options/Blue365 Discount Programs

As a member, you have access to fitness centers, acupuncture, spas, chiropractic care, nutritional counseling, laser vision correction, hearing aids and more. Visit www.carefirst.com/options to learn more.

Dental Savings Plan

BlueChoice Discount Dental Program -- "Save 20%-40% off most dental procedures including routine office visits, x-rays, exams, fillings, root canals and even orthodontics. The BlueChoice Discount Dental Program is included at no additional charge as part of your CareFirst BlueChoice medical plan and is administered by The Dental Network, an independent licensee of the Blue Cross and Blue Shield Association. There is no separate ID card. To get your dental services at discounted fees, simply present your BlueChoice member ID card when you visit any participating provider. There are no claim forms, no maximums, and no deductibles. To find a participating provider, search our online provider directory at www.carefirst.com/pshbp. If you have any questions regarding the discount dental program, please call 844-495-0653.

MediGap-65 and Supplement-65 Medicare Supplemental Plans (For Medicare-eligible individuals in Maryland, District of Columbia and Northern Virginia)

Choose from eight (8) CareFirst Medicare Supplemental plans to give you protection against the important costs Medicare doesn't cover—costs that can add up to thousands of dollars each year.

Dental Plans (For Maryland, District of Columbia and Northern Virginia residents) Regular, preventive dental care is an important part of staying healthy. That's why CareFirst brings you 4 dental plans:

- Dental HMO (Less than $.35 a day) 580+ participating providers and predictable copayments for routine and major dental services (Administered by The Dental Network in MD and CareFirst BlueChoice, Inc. in DC and VA)
- Preferred Dental (Less than $.50 a day) 3,600+ participating providers and 100% coverage for preventive and diagnostic care (Administered by Group Hospitalization and Medical Services, Inc. in DC and VA)
- BlueDental Preferred (Less than $1.00 a day) and Preferred Dental Plus (Less than $1.30 a day) - 63,000+ network providers, 100% coverage for preventive and diagnostic care and extensive benefits for major dental services (Administered by CareFirst of Maryland, Inc. in MD and by Group Hospitalization and Medical Services, Inc. in DC and VA)

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3, *You need prior approval for certain services.***

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies furnished or billed by a non-covered facility, exception being medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan Limits.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B, doctor's charges exceeding the amount specified by the Department of Health Medicare limiting charge, or State premium taxes however applied).
- Services or supplies we are prohibited from covering under the law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at (833) 489-1316, or on our website at www.carefirst.com/pshbp.

In most cases, providers and facilities file claims for you. Provider must file the form CMS-1500, Health Insurance Claim Form. Your facility will file the UB-04 form.

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Name and address of the provider or facility providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment; private duty nursing; and/or physical therapy, occupational therapy, or speech therapy, you must provide a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- We will provide translation and currency conversion services for claims for overseas (foreign) services.

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits there is a (3) three-year limitation on the reissuance of uncashed checks.

Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Records	Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.
Overseas claims	For urgent and emergency services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Overseas Claim Form and the itemized bill to: BlueCard Worldwide Service Center, P.O. Box 72017, Richmond, VA 23255-2017 USA. Obtain Overseas Claim Forms from our website, www.carefirst.com/pshbp. If you have questions about the processing of overseas claims contact (800) 810-2583.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information notified to process your claim.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance) and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website. If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in Section 8a. Medicare PDP EGWP Disputed Claims Process.

Please follow this Postal Service Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114 or calling 833-489-1316

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street, room 3443, NW, Washington, DC 20415.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM’s review within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 833-489-1316. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See Section 8(a).

Section 8(a). Medicare PDP EGWP Disputed Claims Process

When a claim is denied in whole or in part, you may appeal the denial.

Our Plan follows the Medicare Part D appeals process.

Who May Request an Appeal?

You, your prescriber, or someone you name to act for you (your **representative**) may request an appeal. If someone requests an appeal for you, they must send proof of their right to represent you with the request form. Proof could be a power of attorney, a court order, or an Appointment of Representation form. If the person appealing is your prescriber or is authorized under state law to act for you, an Appointment of Representation is not needed.

There Are Two Kinds of Appeals You Can Request

Expedited(72 hours)

You can request an expedited (fast) appeal for cases that involve coverage, if you or your doctor believes that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, the independent reviewer must give you a decision no later than 72 hours after receiving your appeal (the timeframe may be extended in limited circumstances).

- **If the doctor who prescribed the drug(s)** asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, **the independent reviewer will automatically expedite the appeal.**

- If you ask for an expedited appeal without support from a doctor, the independent reviewer will decide if your health requires an expedited appeal. If you do not get an expedited appeal, your appeal will be decided within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.
- **Standard (7 days)**

  You can request a standard appeal for a case involving coverage or payment. The independent reviewer must give you a decision no later than 7 days after receiving your appeal (the timeframe may be extended in limited circumstances).

When the Independent Reviewer Can Extend the Timeframe for Making a Decision

The timeframe may be extended if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request. The timeframe also may be extended when the person acting for you files an appeal request but does not submit proper documentation of representation. In both situations, the independent reviewer may toll (or stop the clock) for up to 14 days to get this information.

How Do I Request an Appeal?
You, your prescriber, or your representative should mail or fax your written appeal request to:

MAXIMUS Federal Services

3750 Monroe Ave., Suite #703

Pittsford, NY 14534-1302

Fax: (585) 425-5301

Toll-free fax: (866) 825-9507

What Do I Include with My Appeal?

You should include your name, address, member ID number, the reasons for appealing, and any evidence you wish to attach. If the appeal is made by someone other than you or your doctor or other prescriber, the person must submit a document appointing him or her to act for you.

If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (formulary) or if you are asking for an exception to a prior authorization (PA) or other utilization management (UM) requirement, your prescribing doctor or other prescriber must submit a statement with your appeal request indicating that all the drugs on any tier of our formulary (or the PA/UM requirement) would not be as effective to treat your condition as the requested drug or would harm your health.

What Happens Next?
If you appeal, the independent reviewer will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can appeal to an administrative law judge (ALJ) if the value of your appeal is at least $190. If you disagree with the ALJ decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

You can also review the five levels of appeal in the Medicare Part D Process as outlined in the Evidence of Coverage which can be obtained at www.carefirst.com/pshbp or by calling 833-489-1316.

If You Need Information or Help call us at:

Toll-free: 1-855-344-0930
24 hours a day, seven days a week

TTY: 711

Other Resources To Help You:

Medicare Rights Center

Toll Free: 1-888-HMO-9050 (1-888-466-9050)

TTY: 1-800-421-1220

Elder Care Locator

Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)

TTY: 1-877-486-2048

24 hours a day, 7 days a week

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.carefirst.com/pshbp.

When we are the primary payor, we will pay the benefits described in this brochure. When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended PSHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these programs, eliminating your PSHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation. Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we paid benefits for that injury, you must agree to the provisions below. These provisions constitute a condition of and a limitation on the nature of benefits or benefit payments and the provision of benefits to you.These provisions apply to all situations where we provide benefits and you have a right to recover damages under any law or type of insurance, including but not limited to:

- Automobile liability, uninsured or underinsured coverage,
- No-fault insurance, regardless of whether that insurance is primary or secondary to other plans,
- Homeowners or property insurance,
- Business, personal or umbrella liability coverage,
- Workers' compensation,

- Payments made directly by responsible individuals,
- Trust funds or accounts established from the proceeds of settlements, judgments, or awards received paid by responsible parties or payors.

All of our benefit payments in these circumstances are conditional, and remain subject to our contractual benefit limitations, exclusions, and maximums. By accepting these conditional benefits, you agree to the following:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how characterized, designated, or apportioned, must be used to reimburse us in full for benefits we paid. Our recovery must be effectuated first before any of the rights of other parties are effectuated. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay. Our lien will apply to any settlements, judgments, and/or recoveries that you obtain from any source, no matter how characterized (e.g., as "pain and suffering" or "non-medical", or "other.")

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits. To avoid any unnecessary delay in processing benefits, it is essential that you and any dependent covered by this plan cooperate with our investigation and recovery efforts. You or your legal representative can also avoid delays by notifying us in writing within 30 days of making a claim against any responsible party or payor for illness or injury that requires medical attention and to notify us at least 10 days prior to reaching agreement with any other responsible party or payor when we have provided benefits for your illness or injury.

Contact us if you need more information about our recovery rights.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some PSHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your PSHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your PSHB plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "When do I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact (833)-489-1316

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.
When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically, and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 833-489-1316 or see our website at www.carefirst.com/pshbp.

We waive some costs if the Original Medicare Plan is your primary payor- we will waive some out-of-pocket costs as follows:

- In-network and Out-of-Network copays, coinsurance and deductibles pertaining to medical services and supplies provided by physicians and other Healthcare professionals.

Please review the following examples which illustrate your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
You Pay without Medicare: Blue Value Plus: None; **BlueChoice Advantage HDHP:** $1,650 Self Only/$3,300 Self Plus One and Self and Family
You Pay with Medicare Part B: Blue Value Plus: None; **BlueChoice Advantage HDHP:** No deductible

Benefit Description: Primary Care Provider
You Pay without Medicare: Blue Value Plus: $10 copay; **BlueChoice Advantage HDHP:** $0 copay
You Pay with Medicare Part B: Blue Value Plus: Nothing; **BlueChoice Advantage HDHP:** Nothing

Benefit Description: Specialist
You Pay without Medicare: Blue Value Plus: $50 copay; **BlueChoice Advantage HDHP:** $35 copay
You Pay with Medicare Part B: Blue Value Plus: Nothing; **BlueChoice Advantage HDHP:** Nothing

Benefit Description: Out-of-Pocket Maximum
You Pay without Medicare: Blue Value Plus: $6,500 Self Only/$13,000 per Self Plus One or Self and Family; **BlueChoice Advantage HDHP:** $5,500 Self Only/$11,000 per Self Plus One or Self and Family
You Pay with Medicare Part B: Standard BlueChoice: Blue Value Plus: $6,500 Self Only/$13,000 per Self Plus One or Self and Family; **BlueChoice Advantage HDHP:** $5,500 Self Only/$11,000 per Self Plus One or Self and Family

Benefit Description: Inpatient Hospital
You Pay without Medicare: Blue Value Plus: 25% of plan allowance; **BlueChoice Advantage HDHP:** After deductible, 20% of plan allowance
You Pay with Medicare Part B: Blue Value Plus: Nothing; **BlueChoice Advantage HDHP:** Nothing

Benefit Description: Outpatient Hospital
You Pay without Medicare:
Standard BlueChoice:
Blue Value Plus: Outpatient Hospital (Non-Surgical): $50 copay per visit; Free standing / Ambulatory Surgical Center: $150 copay; Outpatient Hospital (Surgical): $200 copay
BlueChoice Advantage HDHP: Calendar year deductible applies; $100 copay at an ambulatory surgical center; $300 copay in the outpatient department of a hospital for surgical procedures; $200 for non-surgical hospital outpatient admissions
You Pay with Medicare Part B: Blue Value Plus: Nothing; **BlueChoice Advantage HDHP:** Nothing

Benefit Description: Part B Premium Reimbursement Offered
You Pay without Medicare: Blue Value Plus: No premium reimbursement offered; **BlueChoice Advantage HDHP:** No premium reimbursement offered
You Pay with Medicare: Blue Value Plus: No premium reimbursement offered; **BlueChoice Advantage HDHP:** No premium reimbursement offered

Benefit Description: Incentives Offered
You Pay without Medicare: Blue Value Plus: No incentives offered; **BlueChoice Advantage HDHP:** No incentives offered
You Pay with Medicare:
Blue Value Plus: In-network copays, coinsurance and deductibles pertaining to medical services and supplies provided by physicians and other Healthcare professionals.
BlueChoice Advantage HDHP: In-network and Out-of-Network copays, coinsurance and deductibles pertaining to medical services and supplies provided by physicians and other Healthcare professionals.

You can find more information about how one plan coordinates benefits with Medicare in CareFirst BlueChoice at www.carefirst.com/pshbp

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another non-PSHB plan's Medicare Advantage plan and also remain enrolled in our PSHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended PSHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant, you can suspend your PSHB coverage to enroll in a Medicare Advantage plan, eliminating your PSHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare Part D Prescription Drug Plans**

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

- **Medicare Prescription Drug Plan (PDP); Employer Group Waiver Plan (EGWP)**

If you are enrolled in Medicare Part A and/or Part B, you will be automatically group enrolled into our Medicare PDP EGWP. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note: Y****ou have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

For people with limited income and resources, Extra Help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 TTY 800-325-0778. You may also contact (833) 489-1316.

The PDP EGWP opt out process:

If you were automatically group enrolled into our PDP EGWP and choose to opt out, you can contact us at (833) 489-1316.

The PDP EGWP disenrollment process:

When you are enrolled in our PDP EGWP, you may choose to disenroll at any time, you can contact us at (833) 489-1316.

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note:If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at (833) 489-1316.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have PSHB coverage on your own as an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have PSHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Postal Service and your position is excluded from the PSHB (your employing office will know if this is the case) and you are not covered under PSHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Postal Service and your position is not excluded from the PSHB (your employing office will know if this is the case) and...		
• You have PSHB coverage on your own or through your spouse who is also an active employee		✓
• You have PSHB coverage through your spouse who is an annuitant	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a Postal employee receiving Workers' Compensation		✓*
8) Are a Postal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30-month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30-month coordination period)**		✓
• Medicare based on ESRD **(after the 30-month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have PSHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Allowed benefit

For a contracting physician or contracting provider, the allowed benefit is the lesser of:

The actual charge; or the amount CareFirst BlueChoice allows for the service in effect on the date that the service is rendered.

The benefit payment is made directly to the contracting physician or the contracting provider and is accepted as payment is full, except for any applicable deductible, copayment or coinsurance as stated in the Schedule of Benefits. The member is responsible for any applicable deductible, copayment or coinsurance as stated in the Schedule of Benefits and the contracting physician or contracting provider may bill the member directly for such amounts.

For a non-contracting physician or a non-contracting provider, the allowed benefit for a covered service will be determined in the same manner as the allowed benefit for a contracting physician or contracting provider. Benefits may be paid to the member or to the non-contracting physician or non-contracting provider at the discretion of CareFirst BlueChoice. When benefits are paid to the member, it is the member's responsibility to apply any CareFirst BlueChoice payments to the claim from the non-contracting physician or non-contracting provider.

Note that, under the hearing aid benefit, the provider may have the member sign a document requiring them to pay an amount which exceeds our allowed benefit for certain services.

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Care Plan

A plan of action developed and submitted to CareFirst by a Primary Care Provider (PCP) who is a member of a Patient-Centered Medical Home panel. This is a customized program designed for members who are at risk for, or suffering from, a chronic disease or illness.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

See Section 4, page 25

Copayment

See Section 4, page 25

Cost-sharing

See Section 4, page 25

Covered services

Care we provide benefits for, as described in this brochure.

Deductible

See Section 4, page 25

Experimental or investigational services

We consider services experimental or investigational if they do not meet the following criteria:

- Services legally used in testing or other studies on human patients
- Services recognized as safe and effective for the treatment of a specific condition.
- Services approved by any governmental authority whose approval is required.
- Services approved for human use by the Federal Food and Drug Administration in the case a drug, therapeutic regimen, or device is used.

Group health coverage

Health coverage made available through employment or membership with a particular organization or group.

Healthcare professional

A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

Iatrogenic Infertility

An impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes.

Infertility

Infertility is the inability to conceive or produce conception after 1 year of unprotected sex when an individual is under 35 years of age, or 6 months for an individual age 35 or older or failed attempts at artificial insemination. There are various reproductive treatments available for people facing infertility, which are customized according to their medical history and diagnostic results.

Medical Foods

The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is “a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.” In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Medical necessity

Medically necessary or Medical necessity means health care services or supplies that a health care provider, exercising clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient’s illness, injury or disease;
3. not primarily for the convenience of a patient or health care provider; and
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of health care providers practicing in relevant clinical areas, and any other relevant factors.

The fact that a health care provider may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Contract.

Medicare Part A

Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

Medicare Part B

Part B covers medically necessary services like doctors’ services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

Medicare Part C

Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C plans also include Medicare Part D coverage.

Medicare Part D

Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug Plan (PDP) or as part of a Medicare Advantage Prescription Drug Plan (MAPD).

Medicare Part D EGWP

A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.

Observation care

Hospital outpatient services you get while your doctor decides whether to admit you as an inpatient or discharge you. You can get observation services in the emergency department or another area of the hospital.

	Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient”. If you are not sure if you are an outpatient, you should ask the hospital staff.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Surprise bill	An unexpected bill you receive for: • emergency care – when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.
Us/We	Us and We refer to CareFirst BlueChoice, Inc.
You	You refers to the enrollee and each covered family member.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 833-489-1316. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Benefits -Blue Value Plus for 2025

Do not rely on this chart alone. This is a summary.

All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.carefirst.com/pshbp.

- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Blue Value Plus has no medical deductible. There is a $100 deductible for Self and $200 deductible for Self Plus One and Self and Family for Pharmacy Tiers 2 - Tiers 5.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Blue Value Plus Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	**Preventive Care - No deductible or copay** **In-network**: $15 copay for primary care provider and $50 for a specialist	31
Services provided by a hospital: • Inpatient	**In-network**: 25% of plan allowance	64
Services provided by a hospital: • Outpatient	**In-network:** • Outpatient Hospital (Non-Surgical and clinic visit): $50 copay per visit • Freestanding /Ambulatory Surgical Center: $150 copay • Outpatient Hospital (Surgical): $200 copay	64
Emergency benefits: In-area	**In-Network:** • Emergency Room -$275 copay (waived if admitted) • Emergency Room Professional - $50 copay • Urgent Care Center – $50 copay • Ambulance- $200 copay	68
Emergency benefits: Out-of-area	**In-Network:** • Emergency Room -$275 copay (waived if admitted) • Emergency Room Professional - $50 copay • Urgent Care Center – $50 copay • Ambulance- $200 copay	68
Mental health and substance use disorder treatment**:**	In-Network: Regular cost-sharing.	69
Prescription drugs: • Retail pharmacy	There is a $100 Self Only deductible and $200 Self Plus One and Self and Family deductible for pharmacy for the Blue Value Plus option on Tiers 2 - Tiers 4	72

	Mandatory Generic Drug Substitution benefit indicating that if the member gets a brand-name drug when a generic is available, the member is responsible for the price difference between the brand-name drug and its generic equivalent as well as the brand copay. Retail: up to 34-day supply per copay: Tier 1 Preferred generics - $10 copay, no deductible Tier 2 Preferred brand - Deductible, then $50 copay Tier 3 Preferred specialty generic - Deductible, then $100 copay Tier 4 preferred specialty brand - Deductible, then $150 copay Preferred brand Insulin - No deductible, then $30 Opioid Reversal Agents- No deductible, then $0 copay	
Prescription drugs: • Mail order	There is a $100 Self Only deductible and $200 Self Plus One and Self and Family deductible for pharmacy for the Blue Value Plus option on Tiers 2 - Tiers 4 Mandatory Generic Drug Substitution benefit indicating that if the member gets a brand-name drug when a generic is available, the member is responsible for the price difference between the brand-name drug and its generic equivalent as well as the brand copay. Maintenance Drugs Up to 90-day supply per copayment: Tier 1 Preferred generics - $20 copay, no deductible Tier 2 Preferred brand - Deductible, then $100 copay Tier 3 Preferred specialty generic - Deductible, then $200 copay Tier 4 preferred specialty brand - Deductible, then $300 copay	72
Prescription drugs: • Specialty pharmacy	here is a $100 Self Only deductible and $200 Self Plus One and Self and Family deductible for pharmacy for the Blue Value Plus option on Tiers 2 - Tiers 4 Mandatory Generic Drug Substitution benefit indicating that if the member gets a brand-name drug when a generic is available, the member is responsible for the price difference between the brand-name drug and its generic equivalent as well as the brand copay.	73

	Retail: up to 34-day supply per copay: Tier 1 Preferred generics - $10 copay, no deductible Tier 2 Preferred brand - Deductible, then $50 copay Tier 3 Preferred specialty generic - Deductible, then $100 copay Tier 4 preferred specialty brand - Deductible, then $150 copay Preferred brand Insulin - No deductible, then $30 Opioid Reversal Agents- No deductible, then $0 copay	
Dental care:	No benefit except for services related to an accidental injury	86
Special features: 24-hour nurse line; Care team program; Guest membership. Care plans, Blue Rewards.	No additional cost	87
Protection against catastrophic costs (out-of-pocket maximum):	**In-network**: Nothing after $6,500 Self only, $13,000 Self Plus One and $13,000 for Self and Family for per year based on contract, not members	26
Vision care:	Davis network providers: $10 per visit copay for routine eye exams.	46

Summary of Benefits- HDHP for 2025

Do not rely on this chart alone. This is a summary.

All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.carefirst.com/pshb.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2025, for each month you are eligible for the Health Savings Account, BlueChoice Advantage HDHP will deposit $75 per month for Self-Only enrollment, $150 for Self Plus One enrollment, or $150 per month for Self and Family enrollment to your HSA. For the HSA you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $1,650 in-network and $3,300 out-of-network for Self-Only and $3,300 in-network and $6,600 out-of-network for Self Plus One and Self and Family. Only CareFirst allowable charges are applicable to the deductible. Once you satisfy your calendar year deductible, traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $75 per month for Self-Only enrollment and $150 for Self Plus One and Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, traditional medical coverage begins.

The deductible is $1,650 per Self Only enrollment or $3,300 per Self Plus One and Self and Family enrollment for in-network services and $3,300 per Self Only enrollment and $6,600 per Self Plus One and Self and Family enrollment for out-of-network services each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits unless we indicate differently in Sections 5(a) through 5(g) of this brochure.

Under BlueChoice Advantage, you may earn a medical expense debit card to help pay for qualified medical expenses of up to $400 per Self Only enrollment and up to $800 per Self Plus One and Self and Family enrollment.

HDHP Benefits	You Pay After Calendar Year Deductible	Page
Medical services provider by a physician: Diagnostic and treatment services provided in the office	**In-network**: Preventive Care and Women's Health: No copay All other office care: After deductible, No copay for PCP and $35 for a specialist **Out-of-network**: After deductible, $80 copay	110
Services provided by a hospital: • Inpatient	**In-network**: After deductible, 20% of plan allowance **Out-of-network**: After deductible, 30% of plan allowance	139
Services provided by a hospital: • Outpatient	**In-network**: • Calendar year deductible applies • $100 copay at an ambulatory surgical center • $300 copay in the outpatient department of a hospital for surgical procedures • $200 for non-surgical hospital outpatient admissions and clinic visit **Out-of-network**: • Calendar year deductible applies	139

	• $500 copay at an ambulatory surgical center • $500 copay in the outpatient department of a hospital and clinic visit	
Emergency benefits: • In-area	After the deductible: • $50 copay for Urgent care center • $100 copay for Ambulance services • $300 copay for Emergency room services Note: We waive the ER copay if you are admitted to the hospital	143
Emergency benefits: • Out-of-area	After the deductible: • $50 copay for urgent care center • $150 copay for ambulance services • $300 copay for emergency room services Note: We waive the ER copay if you are admitted to the hospital.	142
Mental health and substance use disorder treatment:	Regular cost sharing	144
Prescription drugs: • Retail pharmacy	**Mandatory Generic Drug Substitution** A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Member is responsible for the price difference between the brand and its generic equivalents as well as the copay. ***Out-of-Network:*** *Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* No deductible for select generic drugs for the treatment of asthma, blood pressure, cholesterol, depression and diabetes After deductible: For up to a 34-day supply: Select Generics - No deductible and $0 • Tier 1 generics - Deductible, then $0 • Tier 2 preferred brand - Deductible, then $50 • Tier 3 non-preferred brand - Deductible, then $75 • Tier 4 preferred specialty - Deductible, then $100 • Tier 5 non-preferred specialty - Deductible, then $150	147

	Preferred and non-preferred brand Insulin - No deductible, then $30 copay Opioid Reversal Agents- Deductible, then $0 For 35-day through 90-day supply, two (2) copays apply for all tiers.	
Prescription drugs: • Mail order	**Mandatory Generic Drug Substitution** A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Member is responsible for the price difference between the brand and its generic equivalents as well as the copay. ***Out-of-Network:*** *Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* Benefit is designed for maintenance drugs only No Deductible for selected generic drugs for the treatment of asthma, blood pressure, cholesterol, depression and diabetes After deductible: Maintenance Drugs: for up to a 34-day supply: Select Generics - No deductible and $0 • Tier 1 generics - Deductible, then $0 • Tier 2 preferred brand - Deductible, then $100 • Tier 3 non-preferred brand - Deductible, then $150 • Tier 4 preferred specialty - Deductible, then $200 • Tier 5 non-preferred specialty - Deductible, then $300 • For 35-day through 90-day supply, two (2) copays apply for all tiers.	147
Prescription drugs: Specialty drugs	**Mandatory Generic Drug Substitution** A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Member is responsible for the price difference between the brand and its generic equivalents as well as the copay. ***Out-of-Network:*** *Members will be responsible for all charges for drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	148

	Benefit is designed for maintenance drugs only No Deductible for selected generic drugs for the treatment of asthma, blood pressure, cholesterol, depression and diabetes After deductible: Maintenance Drugs: for up to a 34-day supply: Select Generics - No deductible and $0 • Tier 1 generics - Deductible, then $0 • Tier 2 preferred brand - Deductible, then $100 • Tier 3 non-preferred brand - Deductible, then $150 • Tier 4 preferred specialty - Deductible, then $200 • Tier 5 non-preferred specialty - Deductible, then $300 • For 35-day through 90-day supply, two (2) copays apply for all tiers	
Dental care:	No benefit except for services related to an accidental injury	162
Vision care:	**In-network**: $10 for routine eye exams **Out-of-network**: You pay all charges Discount program is available for lenses, frames and contacts	121
Special features: 24 nurse line; Care team program; Guest membership; Care plans; Blue Rewards	No additional costs	163
Protection against catastrophic costs (out-of-pocket maximum):	**In-network**: Nothing after $5,500 under a Self-Only enrollment, $11,000 for Self Plus One and $11,000 for Self and Family enrollment per year. **Out-of-network**: After $7,500 on a Self-Only enrollment, $15,000 for Self Plus One and $15,000 for Self and Family enrollment. The member remains liable for charges in excess of our allowed benefit. Some costs do not count toward this protection.	26
Prescription drugs: Medicare PDP EGWP		154

2025 Rate Information for CareFirst BlueChoice, Inc.

To compare your PSHB health plan options please go to https://health-benefits.opm.gov/PSHB/

To review premium rates for all PSHB health plan options please go to https://health-benefits.opm.gov/PSHB/

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
HDHP Option Self Only	K4A	$251.49	$83.83	$544.90	$181.63
HDHP Option Self Plus One	K4C	$502.97	$167.65	$1,089.76	$363.25
HDHP Option Self and Family	K4B	$597.52	$199.17	$1,294.62	$431.54
Blue Value Plus Option Self Only	K4D	$268.28	$89.43	$581.28	$193.76
Blue Value Plus Self Plus One	K4F	$536.57	$178.85	$1,162.56	$387.52
Blue Value Plus Option Self and Family	K4E	$637.43	$212.47	$1,381.09	$460.36