BlueChoice Opt-Out Plus Open Access Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
	Visit www.carefirst.com/doctor to locate providers and facilities	
24-HOUR NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
WELLNESS PROGRAM & BLUE REWARDS		
Visit **www.carefirst.com/myaccount** for more information.	You have access to a comprehensive wellness program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.	
ANNUAL DEDUCTIBLE (Benefit period)[2]		
Individual	None	$300
Family	None	$600
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[3]		
Medical[4]	$1,300 Individual/$2,600 Family	$2,000 Individual/$4,000 Family
Prescription Drug[4]	$4,500 Individual/$9,000 Family	All drug costs are subject to in-network out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	20% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Adult Physical Exam - Not covered Routine GYN Visit - Deductible, then 20% of Allowed Benefit
Breast Cancer Screening	No charge*	Deductible, then 20% of Allowed Benefit
Pap Test	No charge*	20% of Allowed Benefit
Prostate Cancer Screening	No charge*	20% of Allowed Benefit
Colorectal Cancer Screening	No charge*	Deductible, then 20% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	$10 PCP/$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)[5]	No charge*	Deductible, then 20% of Allowed Benefit
Lab[5]	No charge*	Deductible, then 20% of Allowed Benefit
X-ray[5]	No charge*	Deductible, then 20% of Allowed Benefit
Allergy Testing	$10 PCP/$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
Allergy Shots	$10 PCP/$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
Physical, Speech and Occupational Therapy	$20 per visit (limited to 30 visits/injury/benefit period)	Deductible, then 20% of Allowed Benefit
Chiropractic	$20 per visit (limited to 20 visits/benefit period)	Deductible, then 20% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)

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Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
EMERGENCY SERVICES		
Urgent Care Center[6]	$20 per visit	$50 per visit
Emergency Room—Facility Services	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)
Emergency Room—Physician Services	No charge*	No charge*
Ambulance (if medically necessary)	No charge*	Deductible, then 20% of Allowed Benefit
HOSPITALIZATION—(Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	$10 PCP/$20 Specialist per visit	Deductible, then 20% of Allowed Benefit
Inpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	No charge*	Deductible, then 20% of Allowed Benefit
Hospice	No charge*	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility	No charge*	Deductible, then 20% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge*	Deductible, then 20% of Allowed Benefit
Artificial and Intrauterine Insemination[7] (limited to 6 attempts per live birth)	$20 per visit	Not covered
In Vitro Fertilization Procedures[7]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit
Office Visits	No charge*	Deductible, then 20% of Allowed Benefit
Medication Management	No charge*	Deductible, then 20% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	25% of Allowed Benefit	Deductible, then 20% of Allowed Benefit
Hearing Aids for ages 0-18	Not covered	Not covered
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit	Not covered
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

BlueChoice Opt-Out Plus Open Access Summary of Benefits

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

Out-of-network coinsurances are based on a percentage of the out-of-network Allowed Benefit. If services are received from a non-participating provider, the member is responsible for 100% of charges above the Allowed Benefit. However, if services are received from a participating provider, the member is only responsible for amount up to the Allowed Benefit.

* No copayment or coinsurance.

1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

2 For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.

3 For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.

4 Plan has separate out-of-pocket maximums for medical and drug expenses which accumulate independently.

5 Members accessing laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) must use LabCorp as their Lab Test facility and a non-hospital/freestanding facility for X-rays and specialty Imaging for In-Network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered Out-of-Network. Members accessing laboratory, X-rays, and specialty Imaging services outside of Maryland, D.C. or Northern Virginia, may use any participating BlueCard PPO facility and receive out-of-network benefits.

6 Services for non-contracting Urgent Care providers are also covered; please refer to your evidence of coverage for benefit information.

7 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

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

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

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

The benefits described are issued under form numbers: In-Network: VA/CFBC/GC (R. 1/13); VA/CFBC/EOC (R. 1/09); VA/CFBC/DOCS (R. 1/09); VA/BC-OOP/SOB (R. 1/09); VA/BC-OOP/SOB HDHP (9/06); VA/CFBC/BLCRD (R. 1/17); VA/CFBC/HMO/BLCRD (R. 1/17); VA/BC-OOP/VISION (R. 6/04); VA/CFBC/RX3 (R. 1/18); VA/CFBC/ATTC (R. 1/10) and any amendments. Out-of-Network: VA/CF/GC (R. 1/13); VA/CF/BP/EOC (7/08); VA/CF/CMM/DOCS (9/08); VA/CMM/SOB (R. 9/08); VA/CMM/CDH/SOB (9/08); VA/CF/BLCRD (R. 1/17); VA/CF/MEM/BLCRD (R. 1/17); VA/CF/VISION (R. 1/12) VA/CF/ATTC (R. 1/10) and any amendments.

CareFirst

Family of health care plans

BRC7021-1P (4/20) ■ VA ■ 51+ Option 3

In-Network:

10.1 Coverage is Not Provided For:

A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst BlueChoice.
B. Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst BlueChoice.
C. The cost of services that:
   1. Are furnished without charge; or
   2. Are normally furnished without charge to persons without health insurance coverage; or
   3. Would have been furnished without charge if the Member was not covered under the Evidence of Coverage or under any health insurance.
D. Services that are not described as covered in the Evidence of Coverage or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a Primary Care Physician and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.
E. Except for Emergency Services, Urgent Care and follow-up care after emergency surgery, benefits will not be provided for any service(s) provided to a Member by Non-Contracting Physicians or Non-Contracting Providers, unless written prior authorization is specifically obtained from CareFirst BlueChoice.
F. Routine, palliative or cosmetic foot care (except for conditions determined by CareFirst BlueChoice to be Medically Necessary) including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
G. Except for treatment for Accidental Injury or benefits for Oral Surgery as described above, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
H. Benefits will not be provided for cosmetic surgery (except as specifically provided for reconstructive breast surgery and reconstructive surgery as listed above) or other services primarily intended to correct, change or improve appearances.
I. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).
J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility. Benefits for prescription drugs may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services. Over-the-Counter means any item or supply, as determined by CareFirst BlueChoice, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.
L. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.
M. All assisted reproductive technologies (except artificial insemination and intrauterine insemination), including in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.
N. Fees or charges relating to fitness programs, weight loss or weight control programs; physical conditioning; pulmonary rehabilitation programs; exercise programs; and use of passive or patient-activated exercise equipment.
O. Treatment for obesity except for the surgical treatment of Morbid Obesity.
P. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
Q. Services furnished as a result of a referral prohibited by law.
R. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst BlueChoice.
S. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.
T. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.
U. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.
V. Coverage under this Description of Covered Services does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:
   1. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
   2. From any federal, state, county or municipal facility or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that Benefits are payable by the federal, state, county or municipal facility or other government agency and provided at no charge to the Member, but excluding Medicare benefits and Medicaid benefits.

   Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.
W. Private duty nursing.
X. Non-medical, health care provider services, including, but not limited to:
   1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.
   2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Description of Covered Services are available for Covered Services rendered to the Member by a health care provider.
Y. Educational therapies intended to improve academic performance.
Z. Vocational rehabilitation and employment counseling.
AA. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.
BB. Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting and eating (care which may be provided by persons without professional medical skills or training).
CC. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.
DD. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.
EE. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in the Transplants section of this Description of Covered Services).
FF. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
GG. Services required solely for administrative purposes, for example: employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

10.2 Infertility Services

Coverage for Artificial Insemination (and intrauterine insemination) does not include the following:

A. Any costs associated with freezing, storage or thawing of sperm for future attempts or other use.
B. Any charges associated with donor sperm.
C. Infertility services that include the use of any surrogate or gestational carrier service.
D. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures, with or without reversal.
E. All self-administered fertility drugs.

10.3 Organ and Tissue Transplants.

Benefits will not be provided for the following:

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

10.4 Inpatient Hospital Services

Coverage is not provided for the following:

A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.
B. Non-medical items and convenience items, such as television, phone rentals, guest trays and laundry charges.

C. Except for covered Emergency Services and Childbirth, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.
D. Private duty nursing.

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

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

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

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

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

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

Out-of-Network:

10.1 General Exclusions
Coverage is not provided for the following:
A. Any service, test, procedure, supply, or item which CareFirst determines not necessary for the prevention, diagnosis or treatment of the Member's illness, injury, or condition. Although a service may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.
B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which, in the judgment of CareFirst, is Experimental/Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for Clinical Trials.
C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under the Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.
D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that does not meet all other conditions and criteria for coverage as determined by CareFirst.
E. Services that are beyond the scope of the license of the provider performing the service.
F. Routine foot care, including services related to hygiene or any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.
G. Any type of dental care (except treatment of accidental injuries, oral surgery, and cleft lip, cleft palate, or ectodermal dysplasia, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. Benefits for oral surgery are in Section 2.21 of this Description of Covered Services. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.
H. Cosmetic surgery (except benefits for Reconstructive Breast Surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by CareFirst.
I. Treatment rendered by a Health Care Provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
J. Any prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment or unless the prescription drug is specifically identified as covered. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, even though they may be dispensed or administered in a physician or provider office or facility, unless the take-home prescription or medication is specifically identified as covered. Benefits for prescription drugs may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies routinely obtained and self-administered by the Member, except for the CareFirst benefits described in this Evidence of Coverage for diabetic supplies.
L. Food and formula consumed as a sole source or supplemental nutrition, except as listed as a Covered Service in the Evidence of Coverage.
M. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.

N. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation programs are covered as described in this Evidence of Coverage.
O. Medical and surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.
P. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof. Benefits for vision may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.
Q. Services based solely on a court order or as a condition of parole or probation, unless approved by CareFirst.
R. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.
S. Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.
T. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a Health Care Practitioner.
U. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)
V. Private Duty Nursing.
W. Non-medical services, including but not limited to:
    1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services provided by the Health Care Practitioner or the Health Care Practitioner's staff.
    2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a Health Care Provider.

X. Speech Therapy, Occupational Therapy, or Physical Therapy, unless CareFirst determines that the condition is subject to improvement. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.
Y. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers compensation law.
Z. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under Section 2.14, Transplants of this Description of Covered Services), whether or not recommended by an Eligible Provider.
AA. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
BB. Contraceptive drugs or devices, unless specifically identified as covered in this Description of Covered Services, or in a rider or amendment to this Evidence of Coverage.
CC. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
DD. Services, drugs, or supplies the Member receives without charge while in active military service.
EE. Habilitative Services delivered through early intervention and school services.
FF. Custodial Care.
GG. Coverage does not include non-medical Ancillary Services, such as vocational rehabilitation, employment counseling, or educational therapy.
HH. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.
II. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.
JJ. Services required solely for administrative purposes, for example: employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
KK. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

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

10.3 Transplants
Benefits will not be provided for the following:
A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts.
B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.
D. Services for a Member who is an organ donor when the recipient is not a Member.
E. Benefits will not be provided for donor search services.
F. Any service, supply, or device related to a transplant that is not listed as a benefit in the Description of Covered Services.

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

10.5 Home Health Services
Coverage is not provided for:
A. Private Duty Nursing.
B. Custodial Care.

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

10.7 Medical Devices and Supplies
Benefits will not be provided for purchase, rental, or repair of the following:
A. Convenience items. Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench).
B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).
C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).
D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home (e.g., parallel bars).
E. Environmental control equipment. Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.
F. Eyeglasses or contact lenses, except when used as a prosthetic lens replacement for aphakic patients as described in this Description of Covered Services, including, dental prostheses or appliances.
G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories.
H. Medical equipment/supplies of an expendable nature, except as specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.