

Baltimore City Public Schools

Your Employee Benefits

Effective January 1, 2026

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Your City Schools Benefits

As a benefits-eligible Baltimore City Public School employee, you have access to a comprehensive and valuable benefits program that provides health, wellness, and financial benefits coverage. Some benefits are provided to you at no cost; while other benefits may be shared in the cost by you and City Schools. This guide is your source book for your Baltimore City Public Schools health, welfare, and retirement benefits. Use it to find basic information about coverage, eligibility, and benefits enrollment. For more detailed information, refer to the official plan documents and plan policies.

Following is a list of City Schools' benefits available to benefit-eligible employees.

Benefit	Your Options	Who Pays for Coverage
Medical (including prescription drug coverage from Express Scripts)	- CareFirst BlueCross BlueShield Preferred Provider Plan (PPN) - BlueChoice Point-of-Service (POS) - Kaiser Permanente Health Maintenance Organization (HMO) - CareFirst BlueCross BlueShield Major Medical	- You and City Schools share in the cost for coverage in the PPN, POS, and HMO plans - City Schools pays the full cost of coverage in the Major Medical plan
Dental	- CareFirst Dental Preferred Provider (DPPO) - CareFirst Dental Health Maintenance Organization (DHMO)	City Schools pays the full cost of DHMO coverage; you and City Schools share in the cost of DPPO coverage
Vision	- National Vision Administrators Basic Plan - National Vision Administrators Buy-Up Plan	City Schools pays the full cost of basic coverage; you and City Schools share in the cost of buy-up coverage
Employee Assistance Program	ComPsych® GuidanceResources®	City Schools pays the full cost of coverage
Flexible Spending Accounts	- Medical Flexible Spending Account - Dependent Care Flexible Spending Account	Your account is funded by your contributions; City Schools pays administrative costs
Life and Accidental Death and Dismemberment (AD&D)	The Hartford: - Basic Life and AD&D Insurance - Supplemental Life and AD&D Insurance - Spousal Life Insurance - Child Life Insurance	- Basic Life and AD&D Insurance: City Schools pays the full cost of coverage - Supplemental or Dependent coverage: You pay the full cost of coverage at group rates
Disability	The Hartford Long Term Disability	You pay the full cost of coverage at group rates
Retirement	403(b) Investment Plan through TSA Consulting Group 457(b) Investment Plan through TSA Consulting Group - State Retirement and Pension System of Maryland (SRPS) - Employees' Retirement System of Baltimore (ERS) - Retirement Savings Plan, RSP (07/01/2014)	- Investment Plan accounts are funded by your contributions; City Schools pays administrative Costs - SRPS funded by the State of Maryland - ERS funded by the City of Baltimore - RSP funded by the City of Baltimore, Nationwide

Eligibility

Who Is Eligible

Baltimore City Public Schools offers health, welfare, and retirement plans to eligible employees and their eligible dependents. All eligible permanent employees, either full-time or part-time, are entitled to enroll in the plans.

If Both Spouses are Eligible for City Schools' Benefits

Employees/retirees and their eligible dependents may only be enrolled in one City or City Schools medical, dental, prescription drug, and vision plan. This means that if you are a City or City Schools employee or retiree and your spouse is a City or City Schools employee/retiree, both of you cannot enroll in each other's medical, dental, prescription drug, and vision plan during the same plan year. However, you both may have separate policies under your own eligibility status. This same rule applies to eligible dependents.

Dependent Eligibility

City Schools health benefits guidelines require a dependent of an eligible employee to be one of the following:

- A spouse as recognized by the laws of the State of Maryland;
- An unmarried child of an employee until the end of the month in which the child reaches age 26*, when the child is:
 - A child by birth;
 - A legally adopted child;
 - A stepchild residing with the employee;
 - A child residing with the employee and for whom the employee has legal guardianship; or
 - A related child for whom you are economic sole support as determined by City Schools;
- An unmarried child age 26 or older who is otherwise eligible, and who is incapable of self-support due to a mental or physical incapacity, as long as:
 - The disability is due to a mental or physical handicap which existed prior to and continuously since the dependent's 19th birthday, or during a period of student coverage;
 - The child resides permanently with the employee and the employee provides 50% or more of the child's financial support;
 - The child is currently enrolled in one of the City Schools' plans; and
 - You have completed a Disability Qualification Questionnaire and it is approved by the health plan. You may be asked to complete the Disability Qualification Questionnaire again from time to time by the health plan.

*All plans allow unmarried dependent children to be covered up to the end of the month in which they turn age 26.

Enrollment

When You May Enroll in a Health Plan

Type of Enrollment	When You May Enroll
New Employee	You have 30 days from your date of employment to enroll in a health (medical, prescription drug, dental, and/or vision) plan.
Current Employee (when you lose other coverage)	If you decline enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may be able to enroll yourself or your dependents in a City Schools health plan at a later date if your other coverage ends. You must request enrollment within 30 days after your other coverage ends. If you lose coverage because you become ineligible for Medicaid or a state Children’s Health Insurance Program (CHIP), you may request enrollment within 60 days after that coverage ends.
Current Employee (change in family status)	You have 30 days from the date of a family status change (“qualifying event”) – including marriage, birth, adoption, or death – to change your enrollment status in your current health plan. For more information, refer to Qualifying Events for Dependent Enrollment .
Open Enrollment	You have the opportunity to enroll in or change benefit plans on an annual basis each fall for coverage that becomes effective the following January 1st. Each year you will receive instructions on how to enroll.
HIPAA Enrollment	If you decline enrollment for yourself during the plan year but have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s), if you request enrollment within 30 days of the qualifying event.

How to Enroll

As a New Hire

You may enroll for benefits as a new hire by completing a Benefit Selection Form. You must send your completed form and any required documentation to the Department of Employee Services within 30 days of your date of employment to enroll in a health plan (medical, dental, prescription drug, and/or vision).

Mid-Year Changes in Enrollment

To enroll in or make changes during the plan year, you must complete a Benefit Selection Form. You can obtain the form on City Schools’ website at www.baltimorecityschools.org or request one by email from the Human Capital Office at Benefits@bcps.k12.md.us. You may also call (410) 396-8885, Monday through Friday, 8 a.m. to 5 p.m. If you are enrolling dependents (spouse and/or children), you must provide documentation that verifies their relationship to you. For more information, see **Documentation for Dependent Enrollment**, later in this section.

Please complete the entire form and attach the appropriate documentation, if applicable. Return your completed form to:

Human Capital Office, Division of Benefits Management
200 E. North Avenue, Room 110
Baltimore, MD 21202

Once the Human Capital Office receives your completed form and documentation, it will take approximately four to six weeks to process your enrollment request with City Schools and its insurance providers.

During Open Enrollment

Open enrollment is held annually in the fall for coverage that is effective the following January 1st. At that time, information is distributed to employees that describes any upcoming changes to the benefit plans and their associated premium rates. You may enroll in or change your coverage in the following plans during open enrollment:

- Medical (including prescription drug)
- Dental
- Vision
- Supplemental Life and AD&D Insurance
- Spousal Life Insurance
- Child Life Insurance
- Long Term Disability
- Medical Flexible Spending Account
- Dependent Care Flexible Spending Account

Dependent Enrollment

Documentation for Dependent Enrollment

When enrolling a dependent in a health plan, a copy of the following documentation is required. Dependents previously covered before the current plan year require resubmission of documentation.

Relationship to Employee	Documentation for Verification of Relationship
Spouse	Marriage certificate and, if married longer than 12 months, tax return filed within the past two years showing same address for spouse and employee
Dependent Child (by birth)*	Birth certificate
Dependent Child (by adoption or guardianship)*	Birth certificate and official court documents
Stepchild*	Birth certificate and marriage certificate
Disabled Dependent	Birth certificate, completed Disabled Dependent Waiver Request Form (note that the dependent must be covered under the plan prior to age 19)

* Dependent children can be covered up to the end of the month in which they turn age 26.

Qualifying Events for Dependent Enrollment

There are certain family status changes, called qualifying events, that permit you to enroll a dependent in your health plan outside of the annual open enrollment period. To add a dependent mid-year, you must complete a Benefit Selection Form within 30 days of the qualifying event. Benefit Selection Forms received after the 30-day period will not be processed.

Marriage

To add a new spouse, you must complete a Benefit Selection Form providing the spouse's information. In addition, you must attach a copy of the marriage certificate. The Human Capital Office must receive both the form and the marriage certificate within 30 days of the marriage (qualifying event).

Newborn

To add a newborn to your existing health plan effective the day the child is born, you must file a Benefit Selection Form and submit proof of birth within 30 days of the date of birth. On the form, you must list all other eligible dependents covered on your policy. Your new coverage will begin 30 days after the date of birth (qualifying event), however will be retroactive to the date of birth.

Dependent Child (For New Enrollees Only)

To include your eligible dependent child(ren) on your health plan coverage, you must provide a copy of the child(ren's) birth certificate(s).

Stepchildren

To add a stepchild(ren), you must complete and submit a Benefit Selection Form within 30 days of the date of marriage (qualifying event). Coverage will be effective the day the qualifying event occurs. For eligible dependent(s), please see **Documentation for Dependent Enrollment** for guidelines on proof of dependency.

Adopted Children

An adopted child will be covered the day on which the child is adopted or placed for adoption, as long as the Human Capital Office receives your Benefit Selection Form within 30 days of the date of the event. In the dependent section of the application, please write "Adopted Child." For eligible dependents, please see **Documentation for Dependent Enrollment** for guidelines on proof of dependency. You must add your eligible dependents within 30 days of the date of adoption (qualifying event).

Legal Guardianship

You may add an eligible dependent for whom you have legal guardianship to your policy the day of the qualifying event, as long as the Human Capital Office receives your Benefit Selection Form within 30 days of the date of the event. For eligible dependents, please see **Documentation for Dependent Enrollment** for guidelines on proof of dependency. You must add your eligible dependents within 30 days of legal guardianship (qualifying event).

Economic Sole Support

To add an eligible dependent for whom you provide economic sole support, you must submit a Benefit Selection Form to the Office of Benefits Management within 30 days of the qualifying event. Baltimore City Public Schools will determine economic sole support status. Please see **Documentation for Dependent Enrollment** for guidelines on proof of dependency.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in a City Schools health plan, provided that you request enrollment within 30 days after your other coverage ends. You must provide proof of your loss of health insurance.

If you decline enrollment for yourself during the plan year but have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

City Schools will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible; or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the City Schools group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Certificates of Credible Coverage

Employers are required to issue certificates that show evidence of prior health insurance coverage to employees and their eligible dependents. A Certificate of Creditable Coverage is generated by the health care provider when:

- You lose coverage, whether voluntarily or involuntarily; or
- COBRA coverage ends.

When you receive a Certificate of Creditable Coverage, you should keep it in a safe place so that you have it in case you need to provide proof of prior coverage.

When Coverage Begins

If you are a new employee, you must make your benefit elections for medical (including prescription drug), dental, vision, Medical Flexible Spending Account, Dependent Care Flexible Spending Account, Supplemental Life and AD&D Insurance, Spousal Life Insurance, and Child Life Insurance coverage within 30 days of your (benefits eligible) hire date. If we receive your materials within 30 days of your benefit eligible hire date, your coverage will become effective on the first day of the month after your benefit eligible hire date.

If you make a mid-year change to your benefits due to a qualifying event, your coverage becomes effective on the first of the month following the qualifying event. However, when the qualifying event is the birth of a child, coverage will begin on the date of birth, as long as you enroll him or her within 30 days of the date of birth. In all cases, the Human Capital Office must receive your completed Benefit Selection Form within 30 days of the qualifying event for coverage to begin.

For information on when coverage begins for other benefits (Basic, Supplemental, and Dependent Life insurance, Long Term Disability Insurance, and retirement benefits), please refer to the specific section of this guide.

When Coverage Ends

When Your Employment Ends

Your coverage in a City Schools health plan will end at the end of the month in which your employment ends, unless you are a BTU, PSRP, or PSASA member. Coverage for BTU, PSRP, and PSASA members will end on August 31 if the entire school year included 21 premium payments and the employee leaves City Schools in June. However, for all employees, you may be eligible for continued coverage under COBRA. More information on COBRA is provided later in this guide.

If your employment status changes during the year from benefit-eligible to non-benefit-eligible, your coverage ends the first of the following month after the change.

When You Retire

Your coverage in a City Schools health plan will end upon your retirement. However, you may continue to receive health benefits during retirement by re-enrolling with the City of Baltimore. For more information, see **Enrolling for Retiree Health Benefits**.

Qualifying Events for Terminating Dependent Enrollment

Divorce

To remove a spouse (husband or wife) from your health plan due to divorce, submit a copy of the final authorized divorce decree to the Human Capital Office. You will also need to complete a Benefit Selection Form.

Death

To remove a spouse or dependent from your health plan due to death, submit a copy of the death certificate to the Human Capital Office. You will also need to complete a Benefit Selection Form.

Dependent Child Marries

To remove a dependent child from your health plan who has married, submit a copy of the marriage certificate to the Human Capital Office. You will also need to complete a Benefit Selection Form.

Dependent Child No Longer a Dependent

To remove a dependent child from your health plan who is over the maximum age, or no longer eligible to participate under your group plan, submit a Benefit Selection Form to the Human Capital Office.

How to Cancel Coverage

Cancelling Your Coverage

Throughout the year, you may cancel your coverage if you experience a qualifying event (such as divorce, death of a dependent, etc.) and your cancellation of coverage is consistent with that qualifying event (such as canceling coverage for your ex-spouse in the event of a divorce, or cancelling coverage of a dependent child who becomes eligible for his or her own coverage under their employer's plan). You must notify the Human Capital Office within 30 days of the qualifying event by completing a Benefit Selection Form and the appropriate documentation to support your termination. During open enrollment, you may elect to waive your coverage without providing documentation.

It will take approximately four to six weeks to process your request. If you submit your documentation in a timely manner, City Schools will refund any premiums deducted from the date of the qualifying event. Once you have cancelled your health plan coverage, you are not eligible to re-enroll until the next open enrollment period. The premium in existence at the time of re-enrollment will be deducted.

Cancelling a Dependent's Coverage

Throughout the year, you may cancel a dependent's coverage only if you or they experience a qualifying event (such as marriage, divorce, etc.) and your cancellation of coverage is consistent with that qualifying event. In this case, you must submit appropriate documentation. This will assist City Schools in offering your eligible dependents the opportunity to continue their enrollment in City Schools health plans through COBRA. However, you may remove a dependent from your coverage during open enrollment, with the change becoming effective January 1 of the following plan year, without providing any documentation.

We will notify your dependent(s) of their eligibility for COBRA and they must apply for COBRA coverage within 60 days of the qualifying event. It will take approximately four to six weeks to process your enrollment request. Please see **Continuation of Coverage for You or Your Eligible Dependents** for more information.

When You May Make a Change to Your Coverage

Refer to the chart below for an at-a-glance view of when you may make changes to your coverage:

Benefit	When You May Make Changes
Medical (including prescription drug)	• During open enrollment, with changes effective January 1 of the following plan year • Within 30 days of the date you experience a qualifying event; the change in coverage must be consistent with the change in your status
Dental	• During open enrollment, with changes effective January 1 of the following plan year • Within 30 days of the date you experience a qualifying event; the change in coverage must be consistent with the change in your status
Vision	• During open enrollment, with changes effective January 1 of the following plan year • Within 30 days of the date you experience a qualifying event; the change in coverage must be consistent with the change in your status
Flexible Spending Account	• During open enrollment, with changes effective January 1 of the following plan year • Within 30 days of the date you experience a qualifying event; the change in coverage must be consistent with the change in your status
Basic Life and AD&D Insurance	• This coverage is provided automatically, so you cannot make changes
Supplemental Life and AD&D Insurance	• During open enrollment, with changes effective January 1 of the following plan year • Within 30 days of the date you experience a qualifying event; the change in coverage must be consistent with the change in your status
Spousal Life Insurance	• During open enrollment, with changes effective January 1 of the following plan year • Within 30 days of the date you experience a qualifying event; the change in coverage must be consistent with the change in your status
Child Life Insurance	• During open enrollment, with changes effective January 1 of the following plan year • Within 30 days of the date you experience a qualifying event; the change in coverage must be consistent with the change in your status
Long Term Disability Insurance	• During open enrollment, with changes effective January 1 of the following plan year • Within 30 days of the date you experience a qualifying event; the change in coverage must be consistent with the change in your status
Investment Plan (403(b) or 457(b) Plans)	You may make changes to your contributions at any time during the plan year

Medical Child Support Orders (MCSO)

A Medical Child Support Order (MCSO) or a state-issued Qualified Medical Child Support Order (QMCSO) is a judgment, decree, or ruling that provides a child with the right to receive benefits under a parent's health insurance plan. In some cases, an MCSO or QMCSO establishes a parent's obligation to pay child support and provide health insurance coverage for a child. If your City Schools health plan receives an MCSO or QMCSO, the plan will accept the child's enrollment without regard to any enrollment restrictions otherwise stated in this guide.

Coordination of Benefits

If you are married and both you and your spouse have medical coverage, you and members of your family may be covered by more than one medical plan. When this occurs, City Schools medical plans have a Coordination of Benefits (COB) rule that prevents duplicate payment for the same medical expense. The COB rule provides guidance on the order of benefit payment, to determine if the benefits of your City Schools' plan are paid before or after the benefits of the other plan, as follows:

- If your City Schools' plan pays first, benefits under your City Schools' plan will be determined, and then the other plan will determine its benefits (if any) for any remaining expenses.
- If your City Schools' plan pays second, the other plan will determine its benefits first, and then your City Schools' plan will determine its benefits (if any) for any remaining expenses. It is possible your City Schools' benefits will be less than they would have been if your City Schools' plan had paid first. This is because the other plan may have already covered an expense that would have been covered by your City Schools' plan.

Determining Which Plan Pays First

Your City Schools' plan determines benefits based upon the following:

- **An employee's own plan pays first.** If you have a medical expense, your own plan determines its benefits first. Then, if there are any expenses left over, your spouse's plan will determine its benefits (if any). Similarly, if your spouse has a medical expense, your spouse's plan determines its benefits first. Then, if there are expenses left over, your plan will determine its benefits (if any).
- **A dependent child covered by more than one plan.** Unless there is a court decree stating otherwise, the order of benefits is determined as follows:
 - If the parents are married or living together:
 - The benefits of the plan of the parent whose birthday falls earlier in the year are determined first, but
 - If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined first.
 - If the parents are separated, divorced, or not living together, the order of benefits for the dependent child is:
 - The plan of the parent with custody of the child (custodial parent);
 - The plan of the spouse of the parent with custody of the child (custodial stepparent);
 - The plan of the parent not having custody of the child (non-custodial parent); and then
 - The plan of the spouse of the parent who does not have custody of the child (non-custodial stepparent).
- If a person is covered by one plan as an employee and another as a laid-off or retired employee, the plan that covers the person as an active employee pays first.
- If a person is covered by one plan as an employee and another under federal or state continuation coverage, the plan that covers the person as an active employee pays first.
- **If none of the above rules apply,** the plan that covered the employee for a longer period of time pays first.

To apply these COB rules properly, the plan may require you to submit certain information. Separate rules apply for coordinating benefits with Medicare. See **How to Coordinate with Medicare (TEFRA)** later in this guide.

Your Medical Benefits

Your Options

You may choose from three different medical plans:

- BlueChoice Point-of-Service (POS) plan;
- CareFirst Preferred Provider Network (PPN) plan; or
- Kaiser Permanente Health Maintenance Organization (HMO) Signature plan.

Plan Comparison Chart

Following is a high-level chart comparing how much you will pay for several different covered services under each plan. For specific questions about how the plans would cover anything not described here, contact the carrier directly.

Benefits Summary	BlueChoice Point-of-Service		Kaiser Permanente Signature HMO You pay:	CareFirst Blue Cross Blue Shield Preferred Provider Plan	
	In-Plan, you pay:	Out-of-Plan, you pay:		In-Network, you pay:	Out-of-Network, you pay:
HOSPITAL – INPATIENT SERVICES					
Anesthesia	10% allowed benefit	30% allowed benefit	Covered in full	0% allowed benefit	0% allowed benefit
Diagnostic Lab Work and X-rays, Hospital Services, Medical/ Surgical Physician Services, Operating Room Expenses, Physical and Rehabilitation Therapy, and Room, Board, and General Nursing Services	10% allowed benefit; pre-authorization required	30% allowed benefit; pre-authorization required	Covered in full	0% allowed benefit, 365 inpatient days; pre-authorization required	\$100 deductible per admission, then you pay 20% up to \$1,500 out of pocket maximum per admission, then 0% allowed benefit, 365 inpatient days; pre-authorization required
Organ Transplant	10% allowed benefit for non-experimental transplants; pre-authorization required	30% allowed benefit for non-experimental transplants; pre-authorization required	Covered in full for non-experimental kidney, bone marrow, and cornea transplants; for liver, heart, heart-lung, or pancreas, pre-authorization required	0% allowed benefit	20% allowed benefit

Benefits Summary	BlueChoice Point-of-Service		Kaiser Permanente Signature HMO You pay:	CareFirst Blue Cross Blue Shield Preferred Provider Plan	
	In-Plan, you pay:	Out-of-Plan, you pay:		In-Network, you pay:	Out-of-Network, you pay:
HOSPITAL – OUTPATIENT SERVICES					
Chemotherapy	0% allowed benefit	30% allowed benefit	\$10 copay per visit	0% allowed benefit	20% allowed benefit
Colonoscopy	10% allowed benefit	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Diagnostic Lab Work and X-rays	10% allowed benefit	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Outpatient Surgery	10% allowed benefit	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Physical & Rehabilitation Therapy	\$20 copay per visit for practitioner for speech, physical, or occupational therapies; maximum 60 visits per injury or illness per year for short term care	30% allowed benefit, maximum 60 visits per injury or illness per year for short term care	\$10 copay per visit, 30 visits of physical or occupational or speech therapy/year/injury, incident, or condition	0% allowed benefit for 100 visits per calendar year for physical, speech, and occupational therapies combined; pre-certification required after first 10 visits	20% allowed benefit for 100 visits per calendar year for physical, speech, and occupational therapies combined; pre-certification required after first 10 visits
Pre-admission Testing	10% allowed benefit	30% allowed benefit	\$10 copay per visit	0% allowed benefit	20% allowed benefit
Radiation Therapy	0% allowed benefit	30% of allowed benefit	\$10 copay per visit	0% allowed benefit	20% allowed benefit
COMMON AND PREVENTIVE SERVICES					
Doctor’s Office Visits	\$10 copay per visit	30% of allowed benefit	\$5 copay per visit	\$10 copay per visit	20% of allowed benefit
Specialist Office Visits	\$20 copay per visit	30% of allowed benefit	\$10 copay per visit	\$20 copay per visit	20% of allowed benefit
Routine GYN Examinations (one per year)	Covered in full	30% of allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Chlamydia Screening	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Hearing Exams	Covered in full (PCP) (screening only)	30% allowed benefit	\$5 copay for hearing exam (PCP) Hearing screening for newborns covered in full as preventive care services	100% allowed benefit; limited to 1 hearing aid per hearing impaired ear every 3 years	20% allowed benefit; limited to 1 hearing aid per hearing impaired ear every 3 years
Immunizations	Covered in full	30% allowed benefit	Covered in full when done in conjunction with an office visit	Included in well baby visits Hepatitis B vaccination covered in full	20% allowed benefit

Benefits Summary	BlueChoice Point-of-Service		Kaiser Permanente Signature HMO You pay:	CareFirst Blue Cross Blue Shield Preferred Provider Plan	
	In-Plan, you pay:	Out-of-Plan, you pay:		In-Network, you pay:	Out-of-Network, you pay:
COMMON AND PREVENTIVE SERVICES (continued)					
Mammography	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Prostate Screening	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Routine Physical	Covered in full; one per year	30% allowed benefit; one per year	Covered in full; limit one per year	0% allowed benefit; limit one per year	20% allowed benefit; limit one per year
Well Baby Care	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
EMERGENCY TREATMENT					
Ambulance Service	Covered in full, if emergency	30% allowed benefit, if emergency only	Covered in full, if medically necessary	0% allowed benefit (air transport not covered)	100% allowed benefit (air transport not covered)
Emergency Room	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted) then 0% allowed benefit	\$100 copay (waived if admitted) then 0% allowed benefit
Urgent Care Facility	\$10 copay per visit	\$10 copay per visit	\$10 copay per visit	\$10 copay; 0% allowed benefit	\$10 copay; 20% allowed benefit
MATERNITY					
Pre- and Post-Natal Care	Covered in full	30% allowed benefit	\$10 copay for initial visit to determine pregnancy, then covered in full	0% allowed benefit	20% allowed benefit
Delivery (inpatient)	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Newborn Care (inpatient)	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit, initial visit	20% allowed benefit, initial visit

Benefits Summary	BlueChoice Point-of-Service		Kaiser Permanente Signature HMO You pay:	CareFirst Blue Cross Blue Shield Preferred Provider Plan	
	In-Plan, you pay:	Out-of-Plan, you pay:		In-Network, you pay:	Out-of-Network, you pay:
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS – INPATIENT					
Alcohol and Substance Abuse Care	10% allowed benefit; pre-authorization required	30% allowed benefit; pre-authorization required	Covered in full	0% allowed benefit; pre-certification required	\$100 deductible per admission, then 20% up to \$2,000 inpatient out-of-pocket limit maximum per admission then 0% allowed benefit, 365 inpatient days; pre-certification required
Mental Health Benefits	10% allowed benefit; pre-authorization required	30% allowed benefit; pre-authorization required	Covered in full	0% allowed benefit; pre-certification required	\$100 deductible per admission, then 20% up to \$2,000 inpatient out-of-pocket limit maximum per admission, then 0% allowed benefit, 365 inpatient days; pre-certification required
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS – OUTPATIENT					
Alcohol and Substance Abuse Care (office only)	\$10 copay	30% allowed benefit	\$5 copay per visit; pre-authorization required	\$10 copay per visit	20% allowed benefit
Alcohol and Substance Abuse Care (all other outpatient services)	10% allowed benefit	30% allowed benefit	\$5 copay per visit	0% allowed benefit	20% allowed benefit
Mental Health Benefits (office only)	\$10 copay	30% allowed benefit	\$5 copay per visit (no pre-authorization required for outpatient mental health)	\$10 copay	20% allowed benefit
Mental Health Benefits (all other outpatient services)	10% allowed benefit	30% allowed benefit	\$5 copay per visit	0% allowed benefit	20% allowed benefit

Benefits Summary	BlueChoice Point-of-Service		Kaiser Permanente Signature HMO You pay:	CareFirst Blue Cross Blue Shield Preferred Provider Plan	
	In-Plan, you pay:	Out-of-Plan, you pay:		In-Network, you pay:	Out-of-Network, you pay:
OTHER SERVICES AND SUPPLIES					
Allergy Serum	10% allowed benefit	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Diabetic Supplies	10% allowed benefit	30% allowed benefit, including lancets, test strips, and glucometers	Covered in full, including lancets, test strips, disposable insulin needles, and glucometers	0% allowed benefit, including lancets, test strips, and glucometers	0% allowed benefit, including lancets, test strips, and glucometers
Insulin	Insulin and needles covered in full under prescription drug plan after copay				
Family Planning and Fertility Testing	\$20 copay per visit; office visits and diagnostics covered as any other service	30% allowed benefit	\$10 copay per visit for family planning and fertility testing; 50% for other fertility services; IVF limited to 3 attempts per live birth and \$100,000 maximum benefit per lifetime	\$20 copay per visit then 0% allowed benefit	20% allowed benefit
	In-vitro fertilization and related outpatient services are covered with the following restrictions: • Limited to 3 attempts per live birth • Coverage is provided same as physician office services, professional fees, outpatient diagnostic, and therapeutic services • Artificial insemination is covered; maximum of 6 cycles per live birth • Limited to \$100,000 per lifetime • Pre-authorization required				
Home Health Care	10% allowed benefit after prior plan approval	90 days of visits; 30% allowed benefit after prior plan approval	Covered in full	90 days of visits per benefit period; 0% allowed benefit with pre-authorization	90 days of visits per benefit period; 0% allowed benefit with pre-authorization
Private Duty Nursing (outpatient only)	10% allowed benefit for skilled care when medically necessary; prior plan approval required	30% allowed benefit; prior plan approval required	Covered in full for skilled care when medically necessary; prior plan approval required	Mandatory pre-certification and medical necessity; 0% allowed benefit	Mandatory pre-certification and medical necessity; 20% allowed benefit

Benefits Summary	BlueChoice Point-of-Service		Kaiser Permanente Signature HMO You pay:	CareFirst Blue Cross Blue Shield Preferred Provider Plan	
	In-Plan, you pay:	Out-of-Plan, you pay:		In-Network, you pay:	Out-of-Network, you pay:
OTHER SERVICES AND SUPPLIES (continued)					
Durable Medical Supplies (such as crutches and wheelchairs)	10% allowed benefit after prior plan approval	30% allowed benefit; pre-authorization required	Covered in full; pre-authorization required	0% allowed benefit	20% allowed benefit
Hospice Care (inpatient)	10% allowed benefit limited to 180 days lifetime (combined in-plan and out-of-plan); 30 days inpatient per lifetime	30% allowed benefit limited to 180 days lifetime (combined in-plan and out-of-plan); 30 days inpatient per lifetime	Covered in full	0% allowed benefit; pre-authorization required	0% allowed benefit; pre-authorization required
Hospice Care (outpatient)	10% allowed benefit; pre-authorization required (in lieu of hospitalization)	30% allowed benefit; pre-authorization required (in lieu of hospitalization)	Covered in full; pre-authorization required (in lieu of hospitalization)	0% allowed benefit; pre-authorization required	0% allowed benefit; pre-authorization required
Podiatry Services (non-routine)	\$20 copay per visit	30% allowed benefit	\$10 copay per visit	\$20 copay per visit then 0% allowed benefit	20% allowed benefit
Prosthetic Devices (such as artificial limbs)	10% allowed benefit after prior plan approval	30% allowed benefit	Covered in full; prior authorization required, except artificial limbs and artificial eyes; Artificial limbs and artificial eyes \$5 per device; prior authorization required	0% allowed amount	20% allowed amount
Second Surgical Opinions	\$20 copay per visit	30% allowed benefit	\$10 copay per visit	\$20 copay per visit then 0% allowed benefit	20% allowed benefit

MEDICAL BENEFITS

Benefits Summary	BlueChoice Point-of-Service		Kaiser Permanente Signature HMO You pay:	CareFirst Blue Cross Blue Shield Preferred Provider Plan	
	In-Plan, you pay:	Out-of-Plan, you pay:		In-Network, you pay:	Out-of-Network, you pay:
OTHER PLAN FEATURES					
Annual Deductible (plan year)	N/A	N/A	N/A	N/A	N/A
Yearly Out-of-Pocket Maximum (includes mental and nervous coverage)	Individual: \$1,000 Family: \$2,000	N/A	Individual: \$1,100 Family: \$3,600 The following services do not apply to out-of-pocket maximum: • Outpatient drugs, supplies, and supplements, including blood, blood products, and medical foods • Inpatient and outpatient infertility services	Individual: \$400 Family: \$0	Individual: \$2,000 Family: \$4,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Are referrals required in this plan?	No	No	Referrals from PCPs are required except: standing referrals for certain conditions; no referrals required for Outpatient Mental Health, OB/GYN, and eye refraction provided by an Optometrist	No	No
Dependent Eligibility	Dependent children until the end of the month they reach age 26, regardless of student status	Dependent children until the end of the month they reach age 26, regardless of student status	Dependent children until the end of the month they reach age 26, regardless of student status	Dependent children until the end of the month they reach age 26, regardless of student status	Dependent children until the end of the month they reach age 26, regardless of student status

Please note: If you plan to travel overseas, call your health plan for coverage information.

BlueChoice Point-of-Service (POS)

With the BlueChoice Point-of-Service (POS) plan, you can choose your primary care physician (PCP) for yourself and your eligible family members from a broad network of physicians. Your PCP must participate in the CareFirst BlueChoice provider network and specialize in family practice, general practice, pediatrics, or internal medicine.

This description provides a high-level summary of how the plan works. If there is any discrepancy between this description and the official plan documents, the official plan documents will govern how benefits are paid.

How the Plan Works

Receive Care In- or Out-of-Network

The BlueChoice POS plan lets you choose whether to receive care in-network or out-of-network each time you need care. You will receive a higher level of benefits coverage when you use in-network CareFirst BlueChoice providers instead of out-of-network providers. And, some out-of-network providers will cost you more than others. For example, BlueCard® participating providers are physicians who are part of The BlueCross and BlueShield Association national network. If you choose to use a BlueCard® provider, your benefits will be paid at the out-of-network level, but you will pay less because the provider cannot balance bill you for any difference between the allowed amount and actual charges. Other out-of-network providers may charge you for this difference. You can find a national participating provider at www.carefirst.com.

Keep in mind, when you receive care outside of the BlueChoice network, you may have to:

- Pay the provider's actual charge at the time you receive care.
- File a claim for reimbursement.
- Satisfy a higher deductible and/or coinsurance amount.

Referrals

When you need specialty care, referrals are not required under this plan.

For Non-Emergency (Elective) Admissions:

- You or your health care provider must notify CareFirst at least five business days before any scheduled admission.
- You must provide any written information requested by the reviewer at least 24 hours before the admission.
- Within two working days of receiving the information, the reviewer will make an initial determination on whether to approve your elective admission and will notify you and your health care provider of the decision. CareFirst will not provide benefits for an elective admission which is not medically necessary; you will be responsible for the total cost.

For Emergency (Non-Elective) Admissions:

- You, your health care provider, or another person acting on your behalf must notify the reviewer within 24 hours after your admission, or as soon thereafter as possible.
- Within one working day of receiving the information, the reviewer will make an initial determination on whether to approve your non-elective admission and will notify the attending health care provider of the determination. If the reviewer receives notice but still does not approve inpatient benefits, CareFirst will notify the hospital attending health care provider that inpatient benefits will not be paid as of the notification date.
- If you continue the inpatient stay after receiving notice that further care is not medically necessary, you will have to pay all charges.
- If your provider is an out-of-network provider, and the plan does not approve inpatient benefits, you will have to pay the out-of-network provider.
- If your provider is a participating provider, you will not have to pay the provider even if your hospital admission is deemed not medically necessary, or your non-elective admission results in payment denial.

Hospital pre-certification and review is intended to determine the medical necessity of the admission, length of stay, appropriateness of setting and cost effectiveness. Keep the following in mind:

- Procedures normally performed on an outpatient basis will not be approved on an inpatient basis, unless unusual medical conditions are found.
- Pre-operative days will not be approved unless medically necessary.
- The reviewer will assign the number of inpatient days based on clinical condition.
- CareFirst's payment will be based on the number of inpatient days approved by the reviewer.
- CareFirst will provide outpatient benefits for medically necessary covered services when the reviewer does not approve an inpatient admission.
- Hospital pre-certification and review is applicable to maternity services; however, it does not apply for the 48-hour and 96-hour minimum lengths of stay (described in the What's Covered section below).

Case Management

If you have a chronic condition, serious illness, or complex health care needs, you may receive case management services. CareFirst's case management services may include:

- Assessing your/your family's needs related to understanding the disease, treatment plans, self-care, etc.
- Educating you and your family about the disease, treatment, self-care, etc.
- Helping to organize care, including consulting with physicians, arranging for services and supplies, and referring you to community resources.

Second Surgical Opinion

You may get a second surgical opinion before elective surgery to ensure the surgery is necessary and to learn of any alternative treatments. You may also seek a second opinion when required by a hospital's utilization review program.

What's Covered

The BlueChoice POS plan covers a variety of services and supplies when medically necessary. Keep in mind that other limits and exclusions may apply. If there are any discrepancies between this description and the official plan documents, the official plan documents will determine benefits.

Preventive and Wellness Services

- Evidence-based items or services that have in effective a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.
 - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued on or around November 2009.
 - Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
 - With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- If a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, CareFirst will use reasonable medical management techniques to determine any coverage limitations for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.
- CareFirst shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Ambulance Services (non-emergency)

- Medically necessary, non-emergency, surface, and ground ambulance services, as determined by CareFirst.

Controlled Clinical Trial Patient Cost Coverage

- Benefits will be provided to a member in a controlled clinical trial if the member's participation in the controlled clinical trial is the result of:
 - Treatment provided for a life-threatening condition; or
 - Prevention, early detection, and treatment studies on cancer.
- Coverage will be provided only if:
 - The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV controlled clinical trial for cancer; or
 - The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV controlled clinical trial for any other life-threatening condition;
 - The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
 - There is no clearly superior, non-experimental/investigational treatment alternative;

- The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-experimental/investigational alternative; and
- Prior authorization has been obtained from CareFirst.
- Coverage is provided for the patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

Diabetes Services and Supplies

- Diabetes equipment and diabetes supplies: coverage will be provided for all medically necessary and medically appropriate equipment and medically necessary and medically appropriate diabetic supplies when deemed by the treating physician or other appropriately licensed health care provider to be necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy or consistent with the American Diabetes Association's standard, or elevated or impaired blood glucose levels induced by prediabetes.
- Diabetes self-management training:
 - Coverage will be provided for all medically necessary and medically appropriate diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician or other appropriately licensed health care provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.
 - If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified health care provider whose scope of practice includes diabetes education or management.

Emergency Services and Urgent Care

- Covered services:
 - With respect to an emergency medical condition, emergency services evaluation, examination, and treatment to stabilize the member.
 - Medically necessary, emergency surface and ground ambulance services, as determined by CareFirst.
 - Urgent care services.
 - Follow-up care after emergency surgery.
- Follow-up care after emergency surgery is limited to covered services provided by the health care provider who performed the surgical procedure and in consultation with the member's PCP. The member will be responsible for the same copayment for each follow-up visit as would be required for a visit to a contracted health care provider for specialty care.

General Anesthesia for Dental Care

- Benefits for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a member under the following circumstances:
 - If the member is:
 - Seven years of age or younger, or developmentally disabled;
 - An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the member; and
 - An individual for whom a superior result can be expected from dental care provided under general anesthesia.
 - Or, if the member is:
 - Seventeen years of age or younger;
 - An extremely uncooperative, fearful, or uncommunicative individual;
 - An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and
 - An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.
 - Or, if the member has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.
 - Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:
 - A fully accredited specialist in pediatric dentistry;
 - A fully accredited specialist in oral and maxillofacial surgery; and
 - A dentist who has been granted hospital privileges.
 - This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.
 - This provision does not provide benefits for the dental care for which the general anesthesia is provided.

Home Health Care

- Covered services:
 - Home health care, as defined by CareFirst.
 - Home visits following childbirth, including any services required by the attending health care provider:
 - For a member and dependent child(ren) who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or 96 hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the attending health care provider;
 - For a member who, in consultation with her attending health care provider, requests a shorter hospital stay (less than 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated cesarean section):

- One home visit following childbirth scheduled to occur within 24 hours after discharge; and
- An additional home visit following childbirth if prescribed by the attending health care provider.
- An attending health care provider may be an obstetrician, pediatrician, other physician, certified nurse-midwife, or pediatric nurse health care provider, attending the member or newborn dependent child(ren).
- Home visits following childbirth must be rendered, as follows:
 - In accordance with generally accepted standards of nursing practice for home-care of a mother and newborn children; and
 - By a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health.
- Home visits following the surgical removal of a testicle:
 - For a member who receives less than 48 hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis:
 - One home visit following the surgical removal of a testicle scheduled to occur within 24 hours after discharge; and
 - An additional home visit following the surgical removal of a testicle if prescribed by the attending physician.
- Limitations are as follows:
 - The member must be confined to home due to a medical condition. Home cannot be an institution, convalescent home, or any facility which is primarily engaged in rendering medical or rehabilitative services to the sick, disabled, or injured persons.
 - The home health care visits must be a substitute for hospital care or for care in a skilled nursing facility (i.e. if home health care visits were not provided, the member would have to be admitted to a hospital or skilled nursing facility).
 - The member must require and continue to require skilled nursing care or rehabilitative services in order to qualify for home health aide services or other types of home health care. Skilled nursing care, for purposes of home health care, means care that requires licensure as a registered nurse (RN) or licensed practical nurse (LPN) for performance.
 - Services of a home health aide, medical social worker, or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).

Hospice Care

- Hospice care benefits are available for a terminally ill member (medical prognosis by a physician that the member's life expectancy is six months or less) when the member is under the care of a PCP or other health care provider.
 - Inpatient hospice facility services;
 - Part-time nursing care by or supervised by a registered graduate nurse;
 - Counseling, including dietary counseling, for the member;
 - Medical supplies, durable medical equipment, and prescription drugs required to maintain the comfort and manage the pain of the member;

- Medical care by the attending physician;
- Respite care; and
- Other medically necessary health care services at CareFirst’s discretion.
- Additionally, hospice care benefits are available for a member’s family (family is the spouse, parents, siblings, grandparents, child(ren), and/or caregiver) for periodic family counseling before the member’s death, and bereavement counseling.

Infertility Services

- Artificial Insemination/Intrauterine Insemination (AI/IUI)
 - Benefits are available for the diagnosis and treatment of infertility including medically necessary, non-experimental AI/IUI.
 - Benefits are available:
 - For a member whose spouse is of the opposite sex:
 - The member and the member’s spouse have a history of inability to conceive after one year of unprotected vaginal intercourse.
 - The member has had a fertility examination that resulted in a physician’s recommendation advising AI/IUI.
 - The member’s spouse’s sperm is used.
 - For a member whose spouse is of the same sex, the member has had a fertility examination that resulted in a physician’s recommendation advising AI/IUI.
 - For a member whose spouse is of the opposite sex, any charges associated with the collection of the member’s partner’s sperm will not be covered unless the spouse is also a member.
 - For AI/IUI, benefits for the cost of donor oocytes and/or donor sperm are not available.
- In-Vitro Fertilization (IVF)
 - Benefits are available for the diagnosis and treatment of infertility including medically necessary, non-experimental/investigational IVF.
 - Benefits are available:
 - For a member whose spouse is of the opposite sex, the oocytes (eggs) are physically produced by the member and fertilized with sperm physically produced by the member’s spouse, unless:
 - The member’s spouse is unable to produce and deliver functional sperm; and
 - The inability to produce and deliver functional sperm does not result from a vasectomy or another method of voluntary sterilization.
 - The member and the member’s spouse have a history of involuntary infertility which may be demonstrated by a history of:
 - If the member and the member’s spouse are of the opposite sex, an inability to conceive after at least two years of unprotected vaginal intercourse failing to result in pregnancy; or
 - If the member and the member’s spouse are of the same sex, six attempts of artificial insemination over the course of two years failing to result in pregnancy; or

- The infertility is associated with any of the following medical conditions: endometriosis; exposure in utero to diethylstilbestrol, commonly known as DES; blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or abnormal male factors, including oligospermia, contributing to the infertility.
 - The member has been unable to attain a successful pregnancy through less costly infertility treatment for which coverage is available under this evidence of coverage; and
 - The IVF procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists of the American Society for Reproductive Medicine.
- For a member whose spouse is of the opposite sex, charges associated with the collection of the member's partner's sperm are covered if the partner is also a member.
 - For IVF, benefits for the cost of donor oocytes and/or donor sperm are not available.

Inpatient/Outpatient Health Care Provider Services

- Inpatient/outpatient medical care and consultations. Benefits are available for the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the member at a site other than the site where the member is located ("telemedicine services"). Benefits are available for services appropriately provided through telemedicine services, to the same extent as benefits provided for face-to-face consultation or contact between a contracted health care provider and a member. Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a contracted health care provider and a member.
- Support services, including room and board in a semi-private room (or in a private room when medically necessary), and medical and nursing services provided to hospital patients in the course of care including services such as laboratory, radiology, pharmacy, occupational therapy, physical therapy, speech therapy, blood products (both derivatives and components), and whole blood, if not donated or replaced.
- Surgery as follows:
 - Oral surgery, limited to:
 - Surgery involving a bone, joint, or soft tissue of the face, neck, or head to treat a condition caused by disease, accidental injury, and trauma, or congenital deformity not solely involving teeth.
 - Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a member's condition, benefits will be based upon the lowest cost alternative.

Coverage will be provided to repair or replace sound natural teeth that have been damaged or lost due to injury if:

- The injury did not arise while or as a result of biting or chewing; and
- Treatment is commenced within 60 days of the injury. Benefits for such oral surgical services shall be provided up to three years from the date of injury.

Benefits are limited to restoration of the tooth or teeth of the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

- Medically necessary surgical procedures, as determined by CareFirst.
- Reconstructive surgery: benefits are limited to surgical procedures that are medically necessary, as determined by CareFirst, and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma, or previous therapeutic intervention.
- Inpatient/outpatient assistant, if the surgery requires surgical assistance as determined by CareFirst.
- Inpatient/outpatient anesthesia services by a health care provider other than the operating surgeon.
- Inpatient/outpatient chemotherapy.
- Home infusion therapy.
- Inpatient/outpatient radiation therapy.
- Inpatient/outpatient renal dialysis.
- Inpatient/outpatient diagnostic and treatment services provided and billed by a health care provider, including diagnostic procedures, laboratory tests, and x-ray services, including electrocardiograms, electroencephalograms, tomography, laboratory services, diagnostic x-ray services, and diagnostic ultrasound services. Laboratory tests and x-ray services rendered by designated health care providers, whether ordered by a contracted health care provider or a non-contracted health care provider.
- Administration of injectable prescription drugs by a health care provider.
- Allergy-related services, including: allergen immunotherapy (allergy injections), allergenic extracts (allergy sera), and allergy testing.
- Contraceptive exam, insertion, and removal: benefits are available for the insertion or removal, and any medically necessary examination associated with the use of a contraceptive device/prescription drug, approved by the FDA for use as a contraceptive, and prescribed by a health care provider.
- Cleft lip or cleft palate or both: inpatient or outpatient expenses arising from orthodontics, and oral surgery, and otologic, audiological, and speech/language treatment for cleft lip or cleft palate or both.
- Elective sterilization.
- Skilled nursing facility services.
- Spinal manipulation: benefits are limited to medically necessary spinal manipulation, evaluation, and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.
- Treatment of temporomandibular joint (TMJ) dysfunction: medically necessary conservative treatment and surgery, as determined by CareFirst.
- Family planning services, including contraceptive counseling.

Mastectomy-Related Services

- Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy;
- Breast prostheses prescribed by a physician for a member who has undergone a mastectomy and has not had breast reconstruction;
- Physical complications from all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the member; and
- Inpatient hospital services for a minimum of 48 hours following a mastectomy as a result of breast cancer. A member may request a shorter length of stay if the member decides, in consultation with the attending physician, that less time is needed for recovery.
 - For a member who receives less than 48 hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, benefits will be provided for:
 - One home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and
 - An additional home visit if prescribed by the member’s attending physician.
 - For a member who remains in the hospital for at least 48 hours following a mastectomy, coverage will be provided for a home visit if prescribed by the member’s attending physician.

Maternity Services and Newborn Care

- Health care provider services, including:
 - Maternity services:
 - Preventive and prenatal services are provided for all female members including:
 - Outpatient obstetrical care of an uncomplicated pregnancy, including pre-natal evaluation and management office visits, one post-partum office visit, and breastfeeding support (supplies and consultation as provided in the comprehensive guidelines for women’s preventive health supported by the Health Resources and Services Administration); and
 - Prenatal laboratory diagnostic tests and 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 Health Resources and Services Administration.
 - Outpatient obstetrical care and professional services for all prenatal, delivery, and post-partum complications, including, but not limited to, prenatal and post-partum office visits not specifically identified above and ancillary services provided during those visits. These benefits include medically necessary laboratory diagnostic tests and services not identified above, but are not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis;
 - Professional services rendered during a covered hospitalization for an uncomplicated delivery of the child(ren) or for pregnancy-related complications or complications during delivery, including delivery via caesarian section, if the member delivers during that episode of care, and all ancillary services provided during such an event.

- Newborn care services, as follows:
 - Medically necessary services for the normal newborn (an infant born at approximately 40 weeks gestation who has no congenital or comorbid conditions, including but not limited to, neonatal jaundice) including the admission history and physical, and discharge examination;
 - Medically necessary inpatient/outpatient health care provider services for a newborn with congenital or comorbid conditions; and
 - Circumcision.
- Inpatient hospital services in connection with childbirth, for the mother or newborn child(ren), including routine nursery care of the newborn child(ren), are available for:
 - A minimum of:
 - 48 hours following an uncomplicated vaginal delivery; or
 - 96 hours following an uncomplicated caesarean section.
 - Up to four additional days of routine nursery care of the newborn child(ren) when the member is required to remain in the hospital for medically necessary reasons.
- Elective abortions.
- Coverage for victims of rape or incest.
- Birthing classes: one course per pregnancy at a CareFirst-approved facility.
- Birthing centers.
- Benefits are available for universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.
- Benefits are available for comprehensive lactation support and counseling, by a health care provider during the pregnancy and/or in the post-partum period, and breastfeeding supplies and equipment.

Medical Devices and Supplies

- Durable Medical Equipment:
 - Rental, or purchase (at CareFirst's option) and replacements or repairs of medically necessary durable medical equipment prescribed by a contracted health care provider for therapeutic use for a member's medical condition.
 - Durable medical equipment or supplies associated or used in conjunction with medically necessary medical foods and nutritional substances.
 - CareFirst's payment for rental will not exceed the total cost of purchase. CareFirst's payment is limited to the least expensive medically necessary durable medical equipment, adequate to meet the member's medical needs. CareFirst's payment for durable medical equipment includes related charges for handling, delivery, mailing and shipping, and taxes.
- Hair Prosthesis:
 - Benefits are available for a hair prosthesis when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.

- Hearing Aids:
 - Covered services for covered adults and covered dependents, as follows:
 - One hearing aid, prescribed, fitted, and dispensed by a licensed audiologist for each hearing-impaired ear every 36 months; and
 - Non-routine services related to the dispensing of a covered hearing aid, such as assessment, fitting, orientation, conformity, and evaluation.
- Medical Foods and Nutritional Substances:
 - Medically necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a contracted health care provider qualified to provide the diagnosis and treatment in the field of the disorder/disease, as determined by CareFirst.
- Medical Supplies:
 - Benefits are available for medical supplies as such supplies are defined by CareFirst.
- Orthotic Devices and Prosthetic Devices:
 - Except for a prosthetic leg, arm, or eye, benefits provided for orthotic devices and prosthetic devices include:
 - Supplies and accessories necessary for effective functioning of a covered service;
 - Repairs or adjustments to medically necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and
 - Replacement of medically necessary devices when repairs or adjustments fail and/or are not possible.
 - Prosthetic leg, arm, or eye:
 - Coverage shall be provided for an artificial device which replaces, in whole or in part, a leg, an arm, or an eye.
 - Coverage includes:
 - Components of prosthetic leg, arm, or eye; and
 - Repairs to prosthetic leg, arm, or eye.
 - Requirements for medical necessity for coverage of a prosthetic leg, arm, or eye will not be more restrictive than the indications and limitations of coverage and medical necessity established under the medical coverage database.

- Repairs:
 - Benefits for the repair, maintenance, or replacement of a medical device require authorization or approval by CareFirst. Except for benefits for a prosthetic leg, arm, or eye, benefits are limited to:
 - Coverage of maintenance costs is limited to routine servicing, such as testing, cleaning, regulating, and checking of equipment.
 - Coverage of repair costs is limited to adjustment required by normal wear or by a change in the member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the medical device.
 - Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the member or of a family member are not covered.

Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment

- Inpatient/outpatient mental health and substance use disorder services, including behavioral health treatment.

Organ and Tissue Transplants

When Member Is:	Available Benefits
Recipient	Benefits are available for both the member recipient and the non-member donor. Donor services are available only to the extent that benefits are not available from another source, such as other group health plan coverage or health insurance plan.
Donor	No benefits are available.

- Medically necessary, non-experimental/investigational solid organ transplant procedures and bone marrow or other non-solid organ transplant procedures, and related services. Benefits will be provided for high dose chemotherapy/bone marrow or stem cell transplant treatment that is not experimental/investigational as determined by CareFirst.
- Donor services, limited to the extent defined by CareFirst.
- Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant.
- Organ transplant procurement benefits for the recipient, as follows:
 - Health services and supplies used by the surgical team to remove the donor organ.
 - Travel of a hospital surgical team to and from a hospital (other than the organ transplant hospital) where the organ is to be removed from the donor.
 - Transport and storage of the organ, at the organ transplant hospital, in accordance with approved practices.
- Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant is over 50 miles from the recipient's home. Travel is limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. In order to receive travel benefits, a companion must be at least 18 years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under 18 years of age, there may be two companions.

- Additional requirements:
 - The organ transplant hospital must:
 - Have fair and practical rules for choosing recipients and a written contract with someone that has the legal right to procure donor organs;
 - Conform to all laws that apply to organ transplants; and
 - Be approved by CareFirst.
 - At least 30 days before the start of a planned organ transplant, the recipient’s physician must give CareFirst written notice including:
 - Proof of medical necessity;
 - Diagnosis;
 - Type of surgery; and
 - Prescribed treatment.

Outpatient Private Duty Nursing

- Benefits are available for medically necessary outpatient private duty nursing, as determined by CareFirst. Benefits are not provided for private duty nursing rendered in a hospital.

Prescription Drugs

- Benefits for prescription drugs, intended for outpatient use, include injectable prescription drugs that require administration by a health care provider. Additional benefits for prescription drugs, intended for outpatient use, are available as follows:

Pharmacy-Dispensed Prescription Drugs	Prescription Drugs Dispensed in the Office of a Health Care Provider
Benefits are not available through CareFirst for pharmacy-dispensed prescription drugs	Benefits are available, and limited to, prescription drugs dispensed in the office of a health care provider. Contraceptives: benefits are available for injectable prescription drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a health care provider, and dispensed in the office of a health care provider.

Professional Nutritional Counseling/Medical Nutrition Therapy

- Benefits are available for professional nutritional counseling, to include medical nutrition therapy services, when medically necessary as determined by CareFirst.

Rehabilitative and Habilitative Services

- Inpatient Rehabilitative Services: benefits are available for inpatient rehabilitative services.
- Outpatient Rehabilitative Services: benefits are available for the following outpatient rehabilitative services:
 - Occupational therapy;
 - Physical therapy; and
 - Speech therapy.

- **Cardiac Rehabilitation:** benefits for cardiac rehabilitation are provided to a member who has been diagnosed with significant cardiac disease, as defined by CareFirst, or, who, immediately preceding referral for cardiac rehabilitation, suffered a myocardial infarction or has undergone invasive cardiac treatment, as defined by CareFirst. All services must be medically necessary as determined by CareFirst in order to be covered. Services must be provided at a CareFirst-approved place of service equipped and approved to provide cardiac rehabilitation. Benefits will not be provided for maintenance programs.
- **Habilitative Services** (dependent child through the end of the month in which the member turns 19 years old): habilitative services are health care services and devices that help a child keep, learn, or improve skills and functioning for daily living.
 - Benefits for habilitative services will be provided for members until at least the end of the month in which the member turns 19 years old.
 - Benefits include occupational therapy, physical therapy, and speech therapy. Habilitative services for autism or an autism spectrum disorder, include applied behavior analysis services.
- **Pulmonary Rehabilitation:** benefits are provided to members who have been diagnosed with significant pulmonary disease, as defined by CareFirst, or who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all medically necessary services, as determined by CareFirst. Services must be provided at a CareFirst-approved place of service equipped and approved to provide pulmonary rehabilitation. Benefits will not be provided for maintenance programs.
- **Visual Therapy:** benefits are available for outpatient visual therapy.

Surgical Treatment of Morbid Obesity

- Benefits are provided for the surgical treatment of morbid obesity. The procedures must be recognized by the NIH as effective for the long-term reversal of morbid obesity and consistent with guidelines approved by the National Institutes of Health (NIH) and deemed medically necessary by CareFirst.

Vision Care Services: Routine Vision Exam

CareFirst has contracted with Davis Vision, Inc., a national provider of vision care services, to administer vision care benefits on behalf of CareFirst. Covered services are as follows:

- One vision examination per calendar year, including but not limited to:
 - Case history;
 - External examination of the eye and adnexa;
 - Ophthalmoscopic examination;
 - Determination of refractive status;
 - Binocular balancing test;
 - Tonometry test for glaucoma;
 - Gross visual field testing;
 - Color vision testing;
 - Summary finding; and
 - Recommendation, including prescription of corrective lenses.

What's Not Covered

CareFirst POS will not provide a benefit for the following:

- 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.
- Any mental health and substance use disorder services not rendered by the mental health and substance use administrator.
- Services that are not described as covered services or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if medically necessary, by an in-network health care provider does not, by itself, entitle a member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.
- 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 provided, as determined by CareFirst.
- Services or supplies which: were provided at no charge in any federal hospital, or through any federal, state, or local governmental agency or department; were not your legal obligation; or are only charged to insured people. This exclusion does not apply to:
 - Medicaid;
 - Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland; or
 - Care received in a Veteran's hospital unless the care is provided for a condition resulting from military service.
- Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be medically necessary), including flat foot conditions, supportive devices, 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.
- Routine dental care, such as services, supplies, or charges directly related to the care, restoration, removal, or replacement of teeth, and the treatment of disease of the teeth, gums, or structures directly supporting or attached to the teeth. (Note that if you are enrolled in a City Schools' dental plan, these services may be covered under that plan.)
- Cosmetic services (except for mastectomy-related services and services for cleft lip or cleft palate or both).
- Treatment provided by a health care provider who is your parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or who resides in your home.
- All non-prescription drugs, medications, and biologicals routinely obtained and self-administered by you, unless otherwise a covered service.
- All over-the-counter items and supplies, routinely obtained and self-administered by you, including but not limited to: non-prescription eye wear; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and over-the-counter solutions, except for over-the-counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B."
- Lifestyle improvements, including but not limited to, health education classes and self-help programs unless specifically covered in CareFirst's description of covered services.

- Fees or charges related to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment other than medically necessary, and approved pulmonary and/or cardiac rehabilitation program.
- Treatment for weight reduction and obesity, except for the surgical treatment of morbid obesity and covered services provided under the disease management program. This exclusion does not apply to the treatment of childhood obesity, as required by the Patient Protection and Affordable Care Act.
- Routine eyeglasses or contact lenses. (Note: these services may be covered by the City Schools' vision plan.)
- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy or any other forms of refractive keratoplasty or any complications.
- Service furnished as a referral prohibited by law.
- Any recreational activity intended as a rehabilitative service. This includes, but is not limited to: sports, games, horseback riding, and athletic training, even though such service may have therapeutic value or be provided by a health care provider.
- Non-medical health care provider services, including but not limited to:
 - Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services.
 - Administrative fees charged by a health care provider to a member to retain the health care provider's medical practice service, for example, "concierge fees" or boutique medical practice membership fees.
- Educational therapies intended to improve academic performance.
- Vocational rehabilitation and employment counseling.
- Services related to an excluded service (even if they would otherwise be covered) except general anesthesia and associated hospital or ambulatory surgical facility service for dental care.
- Separate billings for services or supplies provided by an employee of a health care provider which are normally included in the health care provider's charges.
- Non-medical services, including but not limited to: personal hygiene, cosmetic items, and convenience items, including but not limited to, air conditioners, humidifiers, exercise equipment, elevators, and ramps.
- Personal comfort items, even when used in an inpatient hospital setting, such as telephones, televisions, guest trays, and laundry charges.
- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, such as bathing, toileting, and eating (care which may be provided by people without professional medical skills or training).
- Treatment of sexual dysfunctions or inadequacies, including but not limited to implants for impotence, medical therapy, and psychiatric treatment.
- Self-care or self-help training designed to help someone cope with a health problem or to modify behavior for improvement of general health, unless otherwise stated.
- Services intended to increase the intelligence quotient (IQ) of a person with an intellectual disability or to provide cure for primary developmental disabilities, if the services do not fall within generally accepted standards of medical care.
- Services for the purpose of controlling or overcoming delinquent, criminal, or socially unacceptable behavior unless deemed medically necessary by CareFirst.
- Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related.

- Services related to human reproduction other than specifically described in the evidence of coverage including, but not limited to maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a member.
- Blood products and whole blood when donated or replaced.
- Oral surgery, dentistry, or dental processes, unless otherwise stated, including removal or replacement of teeth, crowns, bridges, implants, orthodontics except cleft palate, the operation or treatment for the fitting or wearing of dentures, periodontal therapy, direct or indirect restorations (fillings), root canal therapy, treatment of dental cysts and abscesses. (Note that if you are enrolled in one of the City Schools' dental plans, these services may be covered under that plan.)
- Premarital exams.
- Services performed or prescribed by or under the direction of a person who is not a health care provider, or who is acting beyond his/her scope of practice.
- Services provided through a dental or medical department of an employer, a mutual benefit association, a labor union, trust, or similar entity.
- Services provided or available under any workers' compensation or occupational disease, or employer's liability law, or any other similar law, even if you fail to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships, and officers of closed corporations. If a member is exempt from the above laws, the benefits of the evidence of coverage will be provided for covered services.
- Services provided or available through an agent of a school system in response to the requirements of the Individuals with Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are normally covered when provided outside the educational domain.
- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- Exams and related services, and completion of forms, required solely for: employment, pre-employment screening, insurance, foreign travel, travel requirements, school, camp admissions/scouting programs, participation in sports activities (sports physicals), pre-adoption, adoption, pre-foster parenting, foster parenting, admission to old age home, driving license including commercial driving license, handicapped tag documentation, immigration and naturalization, marriage, prison, disability examination, FMLA verification, workers' compensation, attorney forms, or attendance for issue of medical certificates.
- Immunizations solely for foreign travel.
- Charges used to satisfy your dental, prescription drug, or vision plan deductible, if applicable, or balances from any such programs.
- Financial and/or legal services.
- Dietary or nutritional counseling, except as stated in covered services.
- Services solely required or sought on the basis of a court order as a condition of parole or probation unless authorized or approved by CareFirst.
- Work hardening programs, which 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.
- Regarding non-emergency ambulance services, the following are excluded: any air transportation; and except for covered ambulance services, travel, including travel required to return to the service area, whether or not recommended by a health care provider. Additional limited travel benefits related to an organ transplant may be covered if stated in the description of covered services.

- Dental care (even if provided under general anesthesia and the general anesthesia and associated hospital/facility charges are covered).
- Regarding home health care, the following are excluded: rental or purchase of renal dialysis equipment and supplies; Meals-on-Wheels-type food plans; domestic or housekeeping services; care that, after training by skilled personnel, can be provided by a non-health care provider, such as one of the member's family members or a friend (for example, changing wound dressings); and services in the member's home if it is outside the service area.
- Regarding hospice care, the following are excluded: any services other than palliative treatment; rental or purchase of renal dialysis equipment and supplies; domestic or housekeeping services; Meals-on-Wheels-type food plans; services in the member's home if it is outside the service area.
- Regarding reproductive services, the following are excluded:
 - When the member or spouse has undergone elective sterilization with or without reversal.
 - When any surrogate or gestational carrier is used.
 - When the service involves the use of donor embryo(s).
 - Cryopreservation, storage, and/or thawing of sperm, oocytes, or embryo(s).
 - Cost of donor sperm or donor oocytes.
 - When the spouse is of the opposite sex, when the service involves the use of donor oocytes or donor sperm.
 - When the spouse is of the opposite sex, when the service involves collection of the member's spouse's sperm if the member's spouse is not a member.
 - When the spouse is of the same sex, when the service involves the use of donor oocytes.
 - Self-administered fertility drugs (including over the counter medications) that are neither covered under the prescription drug plan nor listed as a covered service.
- Inpatient stays that are primarily for diagnostic service, observation, and/or rehabilitative services; inpatient private duty nursing; a private room when the hospital has semi-private rooms; acupuncture; procedures to reverse sterilization; and surgical removal of impacted teeth.
- Cranial molding orthoses for positional/deformational/non-synostic plagiocephaly or brachycephaly; durable medical equipment or supplies related to non-covered items or services; orthotic and prosthetic devices except as stated in covered services; food and formula consumed as sole source or supplemental nutrition, except as stated in CareFirst's description of covered services.
- Marital counseling, wilderness programs, or boarding schools.
- Organ transplants that are: performed outside the continental United States; due to an employment-related condition; or covered by research funds. The plan also excludes expenses related to finding a suitable donor, such as the National Bone Marrow Registry, search of a population, or mass screening.
- Rehabilitative and habilitative services delivered through early intervention and school services.

Inpatient Pre-Authorization Program

Pre-authorization is required for inpatient hospitalization, with the exception of maternity admissions and admissions for cornea or kidney transplants.

Outpatient Pre-Authorization Program

Certain outpatient services require CareFirst's approval of a plan of treatment before benefits will be paid. You may be subject to a penalty if you do not obtain this approval. The services that require a plan of treatment include:

- Controlled clinical trial patient cost coverage;
- General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care;
- Habilitative services;
- Home health care;
- Hospice care;
- Infertility services; and
- Private duty nursing.

Claims Payment and Appeals

In-Network Providers

With the POS plan, when you use a CareFirst BlueChoice (in-network) provider, he or she files claims for you.

Out-of-Network Providers

You must file claims for services you receive from out-of-network providers, as they have not contracted to be paid directly by CareFirst. Claims for medical benefits must be submitted within 12 months from the date of service, or as soon as is reasonably possible. CareFirst will process the claim within 30 days of receiving it. The claims mailing address is on the claim form. You can obtain claim forms online at www.carefirst.com.

Out-of-Area Care

CareFirst participates in a program called "BlueCard®," which enables you to receive an in-network level of benefits when you are out of your plan's service area. To receive the maximum amount of coverage available, you must receive care from a BlueCard® PPO provider. If you receive care from a provider who is not a BlueCard® PPO provider, generally CareFirst will allow coverage up to CareFirst's allowed benefit. You then pay the difference between CareFirst's allowed benefit and the provider's actual charge.

Appealing a Denied Claim

If your claim is denied and you believe part or all of it should have been paid, you have 180 days from the date of the denial to submit an appeal. You may include additional medical information, comments, records, or other information relating to the claim. Send the appeal with the additional information to:

CareFirst BlueCross BlueShield
National Account Dedicated Service
Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. You will also be permitted to present evidence and testimony as part of the internal claims and appeals process.

CareFirst will respond to your appeal within 60 days of receiving it, unless it is determined that special circumstances require additional time to process the claim. If it is determined that an extension of time for processing is required, you will receive written notice of the extension. In no event will the extension exceed 60 days from the end of the initial 60-day period. You will receive the results of the review in writing.

If your claim is denied after appeal, CareFirst will provide you with notification including:

- The reason why it was denied;
- Reference to the specific plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim;; and
- A statement describing any voluntary appeal procedures available to you.

External Review Process

If your claim is denied after still denied after you appeal the denied claim, you may request an external review of your claim if you file a request for external review within four months after the date you receive the denied benefit determination. Within five business days of receipt of your external review request, CareFirst will complete a preliminary review of your claim. Within one business day after the preliminary review, CareFirst will notify you in writing if the request is not eligible for external review or if it is not complete. If the request is not complete, you will have the opportunity to submit additional information within 48 hours after you receive notification.

CareFirst will assign an Independent Review Organization (IRO) to conduct your external review. The IRO will notify you in writing of the eligibility of your request and acceptance for external review. You have the opportunity to submit any additional information to the IRO within 10 business days following the date you receive notification from the IRO. Within five business days after the IRO is assigned to your external review, CareFirst will provide all documents and information related to your denied appeal to the IRO.

The IRO will provide you with written notice of the final external review decision within 45 days after the IRO receives your request for external review. The notice will include:

- Description of the reason for the external review request;
- The date the IRO was assigned to your external review and the date of the final decision;

- References to evidence or documentation, including specific coverage provisions and evidence-based standards considered in the decision;
- Discussion of the principal reason(s) for its decision;
- Statement that the determination is binding and that judicial review may be available; and
- Contact information for any applicable office of health insurance consumer assistance.

Claim Payment Made in Error

If CareFirst makes a claim payment in error, you are required to repay CareFirst. If you have not repaid the full amount you owe by the time CareFirst pays your next claim, CareFirst may subtract the amount you owe from the next payment.

Assignment of Benefits

You may not assign your right to receive benefits or benefit payments to another person. The only exception is the usual practice of asking CareFirst to pay participating providers directly for services you receive.

CareFirst POS Definitions

Allowed Benefit

- In-network health care providers: for a health care provider that has contracted with CareFirst, the allowed benefit for a covered service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date the service is provided. The benefit is payable to the health care provider and is accepted as payment in full, except for any applicable member payment amounts.
- Out-of-network participating and non-participating health care providers:
 - Out-of-network participating health care providers: for a health care provider that has contracted with CareFirst, the allowed benefit for a covered service is the lesser of the actual charge which, in some cases, will be a rate specified by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the health care provider and is accepted as payment in full, except for any applicable member payment amounts, as stated in the schedule of benefits.
 - Non-participating health care practitioner: for a health care practitioner that has not contracted with CareFirst or CareFirst BlueChoice, the allowed benefit for a covered service is based upon the lesser of the provider's actual charge or established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the subscriber, it is the member's responsibility to pay the health care practitioner. Additionally, the member is responsible for any applicable member payment amounts, as stated in the schedule of benefits, and for the difference between the allowed benefit and the health care practitioner's actual charge.
 - Non-participating hospital or health care facility: for a hospital or health care facility that has not contracted with CareFirst or CareFirst BlueChoice, the allowed benefit for a covered service is based upon the lower of the provider's actual charge or established fee schedule, which in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable member payment amounts, as stated in the schedule of benefits. The benefit is payable to the subscriber or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments

to United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the subscriber, it is the member's responsibility to pay the hospital or health care facility. Additionally, the member is responsible for any applicable member payment amounts, as stated in the schedule of benefits and, unless negotiated, for the difference between the allowed benefit and the hospital or health care facility's actual charge.

- Non-participating emergency services health care provider: CareFirst shall pay the greater of the following amounts for emergency services received from a non-contracted emergency services health care provider:
 - The allowed benefit stated above.
 - The amount negotiated with in-network health care providers for the emergency service provided, excluding any copayment or coinsurance that would be imposed if the service had been received from a contracted emergency services health care provider. If there is more than one amount negotiated with in-network or out-of-network participating health care providers for the emergency service provided, the amount paid shall be the median of these negotiated amounts, excluding any copayment or coinsurance that would be imposed if the service had been received from a contracted emergency services health care provider.
 - The amount for the emergency service calculated using the same method CareFirst generally used to determine payments for services provided by a non-preferred health care provider, excluding any copayment or coinsurance that would be imposed if the service had been received from a contracted emergency services health care provider.
 - The amount that would be paid under Medicare for the emergency service, excluding any copayment or coinsurance that would be imposed if the service had been received from a contracted emergency services health care provider.

Adverse Decision – a utilization review determination that a proposed or delivered health care service covered under your contract is or was not medically necessary, appropriate, or efficient; and may result in non-coverage of the health care service.

Ancillary Services – facility services that may be provided inpatient and/or outpatient. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, durable medical equipment, and medical supplies. Ancillary services do not include room and board services billed by a facility for inpatient care.

Applied Behavior Analysis – the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Benefit Period – the period of time during which covered services are eligible for payment. The benefit period is January 1st through December 31st.

Body Mass Index (BMI) – a practical marker used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Cardiac Rehabilitation – inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process, and enhance the psychosocial and vocational status of eligible members.

CareFirst – CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield.

Caregiver – a person who is not a health care provider who lives with or is the primary caregiver of the member in the home. The caregiver can be a relative by blood, marriage, or adoption, or a friend of the member, but cannot be a person who normally charges for giving services. However, at CareFirst’s discretion, a caregiver may be an employee of a hospice care hospital/agency.

Claims Administrator – CareFirst.

Coinsurance – the percentage of the allowed benefit allocated between CareFirst and the member whereby CareFirst and the member share in the payment for covered services.

Contracted Health Care Provider – for purposes of inter-plan ancillary services, a health care provider who has contracted with the local BlueCross and/or BlueShield Licensee (not CareFirst) and provides ancillary services to the member outside of the CareFirst service area.

Controlled Clinical Trial – a treatment that is:

- Approved by an institutional review board;
- Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and
- Is approved by:
 - The National Institutes of Health (NIH) or a Cooperative Group.
 - The Centers for Disease Control and Prevention.
 - The Agency for Health Care Research and Quality.
 - The Centers for Medicare & Medicaid Services.
 - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs.
 - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
 - The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that has been determined:
 - To be comparable to the system of peer review of studies and investigations used by the NIH; and
 - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - The FDA in the form of an investigational new drug application.
 - An institutional review board of an institution in a state that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH.

Convenience Item – any item that increases physical comfort or convenience without serving a medically necessary purpose, for example, elevators, hooyer/stair lifts, ramps, shower/bath bench, and items available without a prescription.

Cooperative Group – a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative group includes the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the Aids Clinical Trials Group; and the Community Programs For Clinical Research in Aids.

Copayment (copay) – a fixed dollar amount that a member must pay for certain covered services. When a member receives multiple services on the same day by the same health care provider, the member will only be responsible for one copay.

Cosmetic – the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Covered Service – a medically necessary service or supply provided according to the terms of CareFirst's evidence of coverage.

Deductible – the dollar amount of covered services based on the allowed benefit, which must be incurred before CareFirst will pay for all or part of remaining covered services. The deductible is met when the member receives covered services that are subject to the deductible and pays for these him/herself.

Dependent – a member who is covered under the plan as your eligible spouse or eligible child.

Donor Services – services covered under the evidence of coverage which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure, which are directly related to donating the organ or tissue.

Durable Medical Equipment – equipment which:

- Is primarily and customarily used to serve a medical purpose;
- Is not useful to a person in the absence of illness or injury;
- Is ordered or prescribed by a physician or other qualified practitioner;
- Is consistent with the diagnosis;
- Is appropriate for use in the home;
- Is reusable; and
- Can withstand repeated use.

Effective Date – the date on which the member's coverage becomes effective. Covered services rendered on or after the member's effective date are eligible for coverage.

Emergency Medical Condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services – with respect to an emergency medical condition:

- A medical screening examination that is within the capability of the emergency department of a hospital or in an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition;
- Items and services for which benefits are provided or covered under the plan or coverage and that are furnished by a nonparticipating provider or nonparticipating emergency facility, regardless of the department of the hospital in which such items or services are furnished, after the participant, beneficiary,

or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the emergency visit; and

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the member, as defined in the Social Security Act.

Essential Health Benefits – as defined by the Patient Protection and Affordable Care Act, includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Evidence of Coverage – the agreement between the City Schools and CareFirst that describes the details of the plan.

Experimental/Investigational – a service or supply that is in the developmental stage and in the process of human or animal testing excluding Clinical Trial Patient Cost Coverage as stated in CareFirst’s description of covered services. Services or supplies that do not meet all five of the criteria listed below:

- The Technology* must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
- The Technology must improve the net health outcome;
- The Technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside the investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

FDA – the Federal Food and Drug Administration.

Group – the subscriber’s employer/plan sponsor or other organization to which CareFirst has issued the group contract and evidence of coverage.

Group Contract – the agreement issued by CareFirst to the group through which the benefits described in the evidence of coverage are made available. In addition to the evidence of coverage, the group contract includes any riders and/or amendments attached to the group contract or evidence of coverage and signed by an office of CareFirst.

Habilitative Services – health care services and devices, including but not limited to, occupational therapy, physical therapy, and speech therapy that help a child keep, learn, or improve skills and functioning for daily living.

Health Care Provider – a hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide covered services.

Hearing Aid – a device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children and is non-disposable.

Home Health Care – the continued care and treatment of a member by a health care provider in the home if:

- The member is under the care of the PCP or the contracted health care provider;
- The member’s physician establishes and approves in writing the plan of treatment recommending the home health care services; and
- Institutionalization of the member would have been required and deemed medically necessary by CareFirst if the home health care was not provided.

Home Health Care Visit:

- Each visit by a member of a home health care team is considered one home health care visit; and
- Up to four hours of home health care service is considered one home health care visit.

Hospice Care Program – a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement.

Hospice Eligibility Period – the first date hospice care services are rendered and ends 180 days later or on the death of the terminally ill member, if sooner. Any extension of the hospice eligibility period must be authorized or approved by CareFirst.

Incurred – a member’s receipt of a health care service or supply for which a charge was made.

Infusion Therapy – treatment that places therapeutic agents into the vein, including intravenous feeding.

In-Network Health Care Provider – a health care provider that has contracted with CareFirst to render covered services to plan members.

Lifetime Maximum – the maximum dollar amount payable toward a member’s claims for covered services while the member is covered under this group contract. Essential health benefits covered services are not subject to the lifetime maximum.

Limiting Age – the maximum age to which an eligible child may be covered under the plan.

Medical Device – durable medical equipment, hearing aid, medical supplies, orthotic devices, and prosthetic devices.

Medical Director – a board certified physician who is appointed by CareFirst. The duties of the medical director may be delegated to qualified persons.

Medical Nutritional Therapy – provided by a registered dietitian, involves the assessment of the member’s overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition such as cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizure disorders (e.g., ketogenic diet), and other conditions based on the efficacy of diet and lifestyle on the treatment of these disease states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a member’s food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

Medical Supplies – items that:

- Are primarily and customarily used to serve a medical purpose;
- Are not useful to a person in the absence of illness or injury;
- Are ordered or prescribed by a physician or other qualified practitioner;
- Are consistent with the diagnosis;
- Are appropriate for use in the home;
- Cannot withstand repeated use; and
- Are usually disposable in nature.

Medically Necessary or Medical Necessity – health care services or supplies that a health care provider, exercising prudent 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 or supplies are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for a patient’s illness, injury, or disease;
- Not primarily for the convenience of a patient or health care provider; and
- 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.

Member – an individual who meets all applicable eligibility requirements, is enrolled either as a subscriber or dependent, and for whom payment has been received by CareFirst.

Morbid Obesity –

- A body mass index that is greater than 40 kilograms per meter squared; or
- Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

Multiple Project Assurance Contract – a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

Non-Contracted Health Care Provider – for purposes of the inter-plan ancillary services section of this evidence of coverage, a health care provider that does not contract with the local BlueCross and/or BlueShield Licensee (not CareFirst) and provides ancillary services to the member outside of the CareFirst service area, as stated in the inter-plan ancillary services section.

Non-Participating Health Care Provider – a health care provider that does not contract with CareFirst.

Occupational Therapy – 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 who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition.

Open Enrollment – a single period of time each year during which you can change coverage or enroll in coverage. For City Schools’ employees, open enrollment is held during the fall of each year, for an effective date of January 1 of the following year.

Orthotic Device – orthoses and braces which:

- Are primarily and customarily used to serve a therapeutic medical purpose;
- Are prescribed by a health care provider;
- Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;
- May be purely passive support or may make use of spring devices; and
- Includes devices necessary for post-operative healing.

Out-of-Network Participating Health Care Provider – a health care provider contracted with CareFirst to be paid directly for rendering covered services to members.

Out-of-Pocket Maximum – the maximum amount the member will have to pay for his/her share of benefits in any benefit period.

Over-the-Counter – any item or supply, as determined by CareFirst, that is available for purchase without a prescription, unless otherwise a covered service. This includes, but is not limited to, nonprescription eye wear, family planning and contraception products, cosmetics, 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.

Paid Claims – the amount paid by CareFirst for covered services. Inter-plan arrangement fees and compensation are also included in paid claims. Other payments relating to fees and programs applicable to CareFirst’s role as claims administrator may also be included in paid claims.

Patient Cost – the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial. Patient cost does not include the cost of an investigational drug or device, the cost of non-health care services that a member may be required to receive as a result of the treatment being provided for purposes of the clinical trial, costs associated with managing the research associated with the clinical trial, or costs that would not be covered under this evidence of coverage for non-investigational treatments.

Physical Therapy – the short-term treatment described below that can be expected to improve a condition. Physical therapy is the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person’s ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Plan – the portion of the group health plan established by the group that provides for health care benefits for which CareFirst is the claims administrator under this group contract.

Plan of Treatment – the plan written and given to CareFirst by the attending health care provider on CareFirst forms which shows the member's diagnoses and needed treatment.

Prescription Drug:

- A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription."
- Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.
- Prescription drugs do not include:
 - Compounded bulk powders that contain ingredients that:
 - Do not have FDA approval for the route of administration being compounded;
 - Have no clinical evidence demonstrating safety and efficacy; or
 - Do not require a prescription to be dispensed.
 - Compounded drugs that are available as a similar commercially available prescription drug, unless:
 - There is no commercially available bio-equivalent prescription drug; or
 - The commercially available bio-equivalent prescription drug has caused or is likely to cause the member to have an adverse reaction.

Primary Care Provider (PCP) – a health care practitioner in the following disciplines:

- Family practice medicine;
- Adult health medicine;
- General practice medicine;
- Internal practice medicine;
- Pediatric medicine;
- Geriatric medicine; or
- Any other practice area determined by the group.

Private Duty Nursing – skilled nursing care that is not rendered in a hospital/skilled nursing facility.

Professional Nutritional Counseling – individualized advice and guidance given to a member at nutritional risk due to nutritional history, current dietary intake, medication use, or chronic illness, about options and methods for improving nutritional status. Professional nutritional counseling must be provided by a registered licensed dietitian or other eligible health care provider, as determined by CareFirst.

Prosthetic Device – a device which:

- Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or
- Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
- Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
- Is prescribed by a health care provider; and
- Is removable and attached externally to the body.

Rehabilitative Services – includes physical therapy, occupational therapy, and speech therapy for the treatment of individuals who have sustained an illness. The goal is to return the individual to his/her prior skill set and functional level.

Related Services – services or supplies for, or related to, organ/tissue transplant procedures, including but not limited to: diagnostic services, inpatient/outpatient health care provider services, prescription drugs, surgical services, occupational therapy, physical therapy, and speech therapy.

Rescission – a cancellation or discontinuance of coverage that has a retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effectively retroactively to the extent it is attributable to a failure to timely pay charges when due by the group.

Respite Care – short-term care for a member that provides relief to the caregiver.

Service Area – CareFirst's service area, a clearly defined geographic area in which CareFirst has arranged for the provision of health care services to be generally available and readily accessible to members.

Skilled Nursing Care – depending on the place of service or benefit:

- Inpatient hospital/facility or skilled nursing facility:
 - Skilled nursing care rendered on an inpatient basis, means care for medically fragile members with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the member's safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week.
- Skilled nursing care provided in the home:
 - Medically necessary skilled care services performed by a licensed registered nurse (RN) or licensed practical nurse (LPN).
 - Skilled nursing care home visits must be a substitute for hospital care or for care in a skilled nursing facility (i.e., if the visits were not provided, the member would have to be admitted to a hospital or skilled nursing facility).
 - Service of a home health aide, medical social worker, or registered dietician performed under the supervision of a licensed professional (RN or LPN) nurse.
 - Skilled nursing care services in a home health care setting must be based on a plan of treatment submitted by a health care provider.

- Outpatient private duty nursing:
 - Medically necessary skilled care services performed by a licensed registered nurse (RN) or licensed practical nurse (LPN).
 - Skilled nursing care must be a substitute for hospital care or for care in a skilled nursing facility (i.e., if the visits were not provided, the member would have to be admitted to a hospital or skilled nursing facility).
 - Skilled nursing care must be ordered by a physician and based on plan of treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.

Skilled nursing care is not medically necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the activities of daily living (ADL), including but not limited to, bathing, feeding, and toileting is not skilled nursing care.

Skilled Nursing Facility – a licensed institution (or distinct part of a hospital) that provides continuous skilled nursing care and related services if you need medical care, skilled nursing care, or rehabilitative services.

Sound Natural Teeth – teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) and excludes any tooth replaced by artificial means (fixed or removable bridges or dentures).

Specialist – a physician who is certified or trained in a specified field of medicine.

Specialty Drug – prescription drugs which include, but are not limited to, drugs that are very expensive, large molecule, high potential for adverse effects, have stability concerns requiring special handling, and/or are often derived from biologic processes rather than chemical processes. These drugs are often highly effective when used according to a strict administration regimen and therefore may require support and management services.

Speech Therapy – the treatment of communication impairment and swallowing disorders. Speech therapy facilitates the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Subscriber – a member who is covered under this evidence of coverage as an eligible employee or eligible participant of the group, rather than as a dependent.

Type of Coverage – either individual coverage, which covers the subscriber only, or family coverage, under which a subscriber may also enroll his or her dependents. Some group contracts include additional categories of coverage, such as individual and adult and individual and child. The types of coverage available under this evidence of coverage are individual, individual and child, individual and adult, family.

Note: If both the subscriber and dependent spouse qualify as “subscribers” of the group, they may not enroll under separate individual type of coverage memberships, i.e., as separate “subscribers.”

Urgent Care – treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the hospital emergency room. An urgent care facility is a free-standing facility that is not a physician’s office and which provides urgent care.

Waiting Period – the period of time that must pass before an employee or dependent is eligible to enroll under the terms of group of the group health plan. A waiting period determined by the group may not exceed the limits required by applicable federal law and regulation.

For More Information

For more information about the BlueChoice POS plan, visit CareFirst's website at www.carefirst.com, or call CareFirst at 410-581-3506 or toll-free at 1-800-648-5285.

CareFirst BlueCross BlueShield Preferred Provider Network (PPN)

With the CareFirst BlueCross BlueShield Preferred Provider Network (PPN) plan, you have the freedom to choose your own doctors, but you will save money when you use preferred providers. This type of plan is also referred to as a preferred provider option, or PPO. This description provides a high-level summary of how the plan works. If there is any discrepancy between this description and the official plan documents, the official plan documents will govern how benefits are paid.

How the Plan Works

Receive Care In- or Out-of-Network

The CareFirst BlueCross BlueShield PPN plan lets you choose your own doctor or specialist. You do not need to choose a primary care physician (PCP) or get referrals to see a specialist. However, having a regular primary care doctor can help you to stay on track with recommended screenings and preventive care, and help you navigate the health care system. You can choose whether to receive care in-network or out-of-network each time you need care.

In-Network (PPO)/Preferred Providers

If you choose an in-network (PPO) provider, you will pay less than if you use a non-PPO provider. If you have an emergency and a PPO provider is not reasonably available, benefits will be paid as in-network.

Under this plan, you will find that some providers may be “participating” providers, even if they are not “PPO” providers. A participating provider is one that contracts with CareFirst to be paid directly for health care services. A PPO provider has also agreed to charge a certain amount for services and to refer you to specialists within the PPO network.

Whether you receive care from a PPO provider or a participating provider, claims are generally handled as follows:

- The provider submits claims directly to CareFirst.
- CareFirst pays the provider directly.
- You pay any applicable deductible and coinsurance or copay.

Referrals

When you need specialty care, referrals are not required under this plan. However, if a PPO provider gives you a referral to an out-of-network provider, it is typically good for 120 days. If you use the referral within 120 days of receiving it, the covered service will be paid in-network. If you use the referral after 120 days, or if you use it for services beyond what the referral specifies, the covered service will be paid out-of-network. If you ask for a referral to an out-of-network provider, services will be covered as in-network if:

- CareFirst does not contract with a preferred provider qualified to treat the condition or disease; or
- CareFirst cannot provide reasonable access to a qualified preferred provider without unreasonable delay or travel.

Non-Participating Providers

If a PPO provider refers you to a non-participating provider, CareFirst will pay the in-network benefit, and you will be required to pay the difference between CareFirst's payment and the non-participating provider's charge, as follows:

- Either you or the provider may submit the claim to CareFirst, but it is ultimately your responsibility to file the claim on time.
- If you see a non-participating provider, the plan will pay benefits for covered services directly to you. It is your responsibility to pay the provider.
- In the case of a dependent child enrolled due to a court order or qualified medical child support order (QMCSO), the plan will pay benefits directly to the Department of Health and Mental Hygiene or the other parent (not the CareFirst member) if that parent has paid the provider.
- You are responsible for paying the difference between CareFirst's payment and the non-participating provider's charge.

For Non-Emergency (Elective) Admissions:

- You must provide any written information requested by the reviewer at least 24 hours before the admission.
- Within two working days of receiving the information, the reviewer will make an initial determination on whether to approve your elective admission and will notify you and your health care provider of the decision. CareFirst will not provide benefits for an elective admission which is not medically necessary; you will be responsible for the total cost.

For Emergency (Non-Elective) Admissions:

- You, your health care provider, or another person acting on your behalf must notify the reviewer within 24 hours after your admission, or as soon thereafter as possible.
- Within one working day of receiving the information, the reviewer will make an initial determination on whether to approve your non-elective admission and will notify the attending health care provider of the determination. If the reviewer receives notice but still does not approve inpatient benefits, CareFirst will notify the hospital attending health care provider that inpatient benefits will not be paid as of the notification date.
- If you continue the inpatient stay after receiving notice that further care is not medically necessary, you will have to pay all charges.
- If your provider is a non-participating provider, and the plan does not approve inpatient benefits, you will have to pay the non-participating provider.
- If your provider is a participating provider, you will not have to pay the provider even if your hospital admission is deemed not medically necessary, or your non-elective admission results in payment denial.
- Hospital pre-certification and review is intended to determine the medical necessity of the admission, length of stay, appropriateness of setting, and cost effectiveness. Keep the following in mind:
 - Procedures normally performed on an outpatient basis will not be approved on an inpatient basis, unless unusual medical conditions are found.
 - Pre-operative days will not be approved unless medically necessary.
 - The reviewer will assign the number of inpatient days based on clinical condition.

- CareFirst’s payment will be based on the number of inpatient days approved by the reviewer.
- CareFirst will provide outpatient benefits for medically necessary covered services when the reviewer does not approve an inpatient admission.
- Hospital pre-certification and review is applicable to maternity services; however, it does not apply for the 48-hour and 96-hour minimum lengths of stay (described in the What’s Covered section below).

Case Management

If you have a chronic condition, serious illness, or complex health care needs, you may receive case management services. CareFirst’s case management services may include:

- Assessing your/your family’s needs related to understanding the disease, treatment plans, self-care, etc.
- Educating you and your family about the disease, treatment, self-care, etc.
- Helping to organize care, including consulting with physicians, arranging for services and supplies, and referring you to community resources.

Second Surgical Opinion

You may get a second surgical opinion before elective surgery to ensure the surgery is necessary and to learn of any alternative treatments. You may also seek a second opinion when required by a hospital’s utilization review program.

What’s Covered

The CareFirst PPN plan covers a variety of services and supplies when medically necessary. Keep in mind that other limits and exclusions may apply. If there are any discrepancies between this description and the official plan documents, the official plan documents will determine benefits.

Preventive and Wellness Services

- Evidence-based items or services that have in effective a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.
 - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued on or around November 2009.
 - Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
 - With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- If a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, CareFirst will use reasonable medical management techniques to determine any coverage limitations for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.
- CareFirst shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Ambulance Services (non-emergency)

- Medically necessary, non-emergency, surface, and ground ambulance services, as determined by CareFirst.

Controlled Clinical Trial Patient Cost Coverage

- Benefits will be provided to a member in a controlled clinical trial if the member's participation in the controlled clinical trial is the result of:
 - Treatment provided for a life-threatening condition; or
 - Prevention, early detection, and treatment studies on cancer.
- Coverage will be provided only if:
 - The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV controlled clinical trial for cancer; or
 - The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV controlled clinical trial for any other life-threatening condition;
 - The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
 - There is no clearly superior, non-experimental/investigational treatment alternative;
 - The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-experimental/investigational alternative; and
 - Prior authorization has been obtained from CareFirst.
- Coverage is provided for the patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

Diabetes Services and Supplies

- Diabetes equipment and diabetes supplies: coverage will be provided for all medically necessary and medically appropriate equipment and medically necessary and medically appropriate diabetic supplies when deemed by the treating physician or other appropriately licensed health care provider to be necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy or consistent with the American Diabetes Association's standard, or elevated or impaired blood glucose levels induced by prediabetes.
- Diabetes self-management training:
 - Coverage will be provided for all medically necessary and medically appropriate diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician or other appropriately licensed health care provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.
 - If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified health care provider whose scope of practice includes diabetes education or management.

Emergency Services and Urgent Care

- Covered services:
 - With respect to an emergency medical condition, emergency services evaluation, examination, and treatment to stabilize the member.
 - Medically necessary, emergency surface and ground ambulance services, as determined by CareFirst.
 - Urgent care services.

General Anesthesia for Dental Care

- Benefits for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a member under the following circumstances:
 - If the member is:
 - Seven years of age or younger, or developmentally disabled;
 - An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the member; and
 - An individual for whom a superior result can be expected from dental care provided under general anesthesia.
 - Or, if the member is:
 - Seventeen years of age or younger;
 - An extremely uncooperative, fearful, or uncommunicative individual;
 - An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and
 - An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.
 - Or, if the member has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.
 - Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:
 - A fully accredited specialist in pediatric dentistry;
 - A fully accredited specialist in oral and maxillofacial surgery; and
 - A dentist who has been granted hospital privileges.
 - This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.
 - This provision does not provide benefits for the dental care for which the general anesthesia is provided.

Home Health Care

- Covered services:
 - Home health care, as defined by CareFirst.
 - Home visits following childbirth, including any services required by the attending health care provider:
 - For a member and dependent child(ren) who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or 96 hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the attending health care provider;
 - For a member who, in consultation with her attending health care provider, requests a shorter hospital stay (less than 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated cesarean section):
 - One home visit following childbirth scheduled to occur within 24 hours after discharge; and
 - An additional home visit following childbirth if prescribed by the attending health care provider.
 - An attending health care provider may be an obstetrician, pediatrician, other physician, certified nurse-midwife, or pediatric nurse health care provider, attending the member or newborn dependent child(ren).
 - Home visits following childbirth must be rendered, as follows:
 - In accordance with generally accepted standards of nursing practice for home care of a mother and newborn child(ren); and
 - By a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health.
 - Home visits following the surgical removal of a testicle:
 - For a member who receives less than 48 hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis:
 - One home visit following the surgical removal of a testicle scheduled to occur within 24 hours after discharge; and
 - An additional home visit following the surgical removal of a testicle if prescribed by the attending physician.
- Limitations are as follows:
 - The member must be confined to home due to a medical condition. Home cannot be an institution, convalescent home, or any facility which is primarily engaged in rendering medical or rehabilitative services to the sick, disabled, or injured persons.
 - The home health care visits must be a substitute for hospital care or for care in a skilled nursing facility (i.e. if home health care visits were not provided, the member would have to be admitted to a hospital or skilled nursing facility).
 - The member must require and continue to require skilled nursing care or rehabilitative services in order to qualify for home health aide services or other types of home health care. Skilled nursing care, for purposes of home health care, means care that requires licensure as a registered nurse (RN) or licensed practical nurse (LPN) for performance.
 - Services of a home health aide, medical social worker, or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).

Hospice Care

- Hospice care benefits are available for a terminally ill member (medical prognosis by a physician that the member's life expectancy is six months or less) when the member is under the care of a PCP or other health care provider.
 - Inpatient hospice facility services;
 - Part-time nursing care by or supervised by a registered graduate nurse;
 - Counseling, including dietary counseling, for the member;
 - Medical supplies, durable medical equipment, and prescription drugs required to maintain the comfort and manage the pain of the member;
 - Medical care by the attending physician;
 - Respite care; and
 - Other medically necessary health care services at CareFirst's discretion.
- Additionally, hospice care benefits are available for a member's family (family is the spouse, parents, siblings, grandparents, child(ren), and/or caregiver) for periodic family counseling before the member's death, and bereavement counseling.

Infertility Services

- Artificial Insemination/Intrauterine Insemination (AI/IUI)
 - Benefits are available for the diagnosis and treatment of infertility including medically necessary, non-experimental AI/IUI.
 - Benefits are available:
 - For a member whose spouse is of the opposite sex:
 - The member and the member's spouse have a history of inability to conceive after one year of unprotected vaginal intercourse.
 - The member has had a fertility examination that resulted in a physician's recommendation advising AI/IUI.
 - The member's spouse's sperm is used.
 - For a member whose spouse is of the same sex, the member has had a fertility examination that resulted in a physician's recommendation advising AI/IUI.
 - For a member whose spouse is of the opposite sex, any charges associated with the collection of the member's partner's sperm will not be covered unless the spouse is also a member.
 - For AI/IUI, benefits for the cost of donor oocytes and/or donor sperm are not available.
- In-Vitro Fertilization (IVF)
 - Benefits are available for the diagnosis and treatment of infertility including medically necessary, non-experimental/investigational IVF.
 - Benefits are available:
 - For a member whose spouse is of the opposite sex, the oocytes (eggs) are physically produced by the member, and fertilized with sperm physically produced by the member's spouse, unless:
 - The member's spouse is unable to produce and deliver functional sperm; and
 - The inability to produce and deliver functional sperm does not result from a vasectomy or another method of voluntary sterilization.

- The member and the member's spouse have a history of involuntary infertility which may be demonstrated by a history of:
 - If the member and the member's spouse are of the opposite sex, an inability to conceive after at least two years of unprotected vaginal intercourse failing to result in pregnancy; or
 - If the member and the member's spouse are of the same sex, six attempts of artificial insemination over the course of two years failing to result in pregnancy; or
 - The infertility is associated with any of the following medical conditions: endometriosis; exposure in utero to diethylstilbestrol, commonly known as DES; blockage of, or surgical removal of one or both fallopian tubes (lateral or bilateral salpingectomy); or abnormal male factors, including oligospermia, contributing to the infertility.
- The member has been unable to attain a successful pregnancy through less costly infertility treatment for which coverage is available under this evidence of coverage; and
- The IVF procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists of the American Society for Reproductive Medicine.
- For a member whose spouse is of the opposite sex, charges associated with the collection of the member's partner's sperm are covered if the partner is also a member.
- For IVF, benefits for the cost of donor oocytes and/or donor sperm are not available.

Inpatient/Outpatient Health Care Provider Services

- Inpatient/outpatient medical care and consultations. Benefits are available for the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the member at a site other than the site where the member is located ("telemedicine services"). Benefits are available for services appropriately provided through telemedicine services, to the same extent as benefits provided for face-to-face consultation or contact between a contracted health care provider and a member. Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a contracted health care provider and a member.
- Support services, including room and board in a semi-private room (or in a private room when medically necessary), and medical and nursing services provided to hospital patients in the course of care including services such as laboratory, radiology, pharmacy, occupational therapy, physical therapy, speech therapy, blood products (both derivatives and components), and whole blood, if not donated or replaced.
- Surgery as follows:
 - Oral surgery, limited to:
 - Surgery involving a bone, joint, or soft tissue of the face, neck, or head to treat a condition caused by disease, accidental injury, and trauma, or congenital deformity not solely involving teeth.
 - Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a member's condition, benefits will be based upon the lowest cost alternative.

Coverage will be provided to repair or replace sound natural teeth that have been damaged or lost due to injury if:

- The injury did not arise while or as a result of biting or chewing; and
- Treatment is commenced within 60 days of the injury. Benefits for such oral surgical services shall be provided up to three years from the date of injury.

Benefits are limited to restoration of the tooth or teeth of the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

- Medically necessary surgical procedures, as determined by CareFirst. If multiple surgical procedures are performed during the same operative session, CareFirst will review the procedures to determine the benefits provided:
 - If the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the evidence of coverage based on the allowed benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.
 - If the additional procedures are not clinically integral to the primary procedure, including but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the evidence of coverage based on the allowed benefit for the most clinically intense surgical procedure, and the allowed benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.
- Reconstructive surgery: benefits are limited to surgical procedures that are medically necessary, as determined by CareFirst, and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma, or previous therapeutic intervention.
- Inpatient/outpatient assistant, if the surgery requires surgical assistance as determined by CareFirst.
- Inpatient/outpatient anesthesia services by a health care provider other than the operating surgeon.
- Inpatient/outpatient chemotherapy.
- Home infusion therapy.
- Inpatient/outpatient radiation therapy.
- Inpatient/outpatient renal dialysis.
- Inpatient/outpatient diagnostic and treatment services provided and billed by a health care provider, including diagnostic procedures, laboratory tests, and x-ray services, including electrocardiograms, electroencephalograms, tomography, laboratory services, diagnostic x-ray services, and diagnostic ultrasound services.
- Administration of injectable prescription drugs by a health care provider.
- Acupuncture.
- Allergy-related services, including: allergen immunotherapy (allergy injections), and allergy testing.
- Contraceptive exam, insertion, and removal: benefits are available for the insertion or removal, and any medically necessary examination associated with the use of a contraceptive device/prescription drug, approved by the FDA for use as a contraceptive, and prescribed by a health care provider.

- Cleft lip or cleft palate or both: inpatient or outpatient expenses arising from orthodontics, and oral surgery, and otologic, audiological, and speech/language treatment for cleft lip or cleft palate or both.
- Elective sterilization.
- Skilled nursing facility services.
- Spinal manipulation: benefits are limited to medically necessary spinal manipulation, evaluation, and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.
- Treatment of temporomandibular joint (TMJ) dysfunction: medically necessary conservative treatment and surgery, as determined by CareFirst.
- Family planning services, including contraceptive counseling.

Mastectomy-Related Services

- Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy;
- Breast prostheses prescribed by a physician for a member who has undergone a mastectomy and has not had breast reconstruction;
- Physical complications from all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the member; and
- Inpatient hospital services for a minimum of 48 hours following a mastectomy as a result of breast cancer. A member may request a shorter length of stay if the member decides, in consultation with the attending physician, that less time is needed for recovery.
 - For a member who receives less than 48 hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, benefits will be provided for:
 - One home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and
 - An additional home visit if prescribed by the member's attending physician.
 - For a member who remains in the hospital for at least 48 hours following a mastectomy, coverage will be provided for a home visit if prescribed by the member's attending physician.

Maternity Services and Newborn Care

- Health care provider services, including:
 - Maternity services:
 - Preventive and prenatal services are provided for all female members including:
 - Outpatient obstetrical care of an uncomplicated pregnancy, including prenatal evaluation and management office visits, one post-partum office visit, and breastfeeding support (supplies and consultation as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration); and

- Prenatal laboratory diagnostic tests and 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 Health Resources and Services Administration.
- Outpatient obstetrical care and professional services for all prenatal, delivery, and post-partum complications, including but not limited to, prenatal and post-partum office visits not specifically identified above and ancillary services provided during those visits. These benefits include medically necessary laboratory diagnostic tests and services not identified above, but are not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis;
- Professional services rendered during a covered hospitalization for an uncomplicated delivery of the child(ren) or for pregnancy-related complications or complications during delivery, including delivery via caesarian section, if the member delivers during that episode of care, and all ancillary services provided during such an event.
- Newborn care services, as follows:
 - Medically necessary services for the normal newborn (an infant born at approximately 40 weeks gestation who has no congenital or comorbid conditions, including but not limited to, neonatal jaundice) including the admission history and physical, and discharge examination;
 - Medically necessary inpatient/outpatient health care provider services for a newborn with congenital or comorbid conditions; and
 - Circumcision.
- Inpatient hospital services in connection with childbirth for the mother or newborn child(ren), including routine nursery care of the newborn child(ren), are available for:
 - A minimum of:
 - 48 hours following an uncomplicated vaginal delivery; or
 - 96 hours following an uncomplicated caesarean section.
 - Up to four additional days of routine nursery care of the newborn child(ren) when the member is required to remain in the hospital for medically necessary reasons.
- Elective abortions.
- Coverage for victims of rape or incest.
- Birthing centers.
- Benefits are available for universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.
- Benefits are available for comprehensive lactation support and counseling, by a health care provider during the pregnancy and/or in the post-partum period, and breastfeeding supplies and equipment.

Medical Devices and Supplies

- Durable Medical Equipment:
 - Rental, or purchase (at CareFirst's option), and replacements or repairs of medically necessary durable medical equipment prescribed by a contracted health care provider for therapeutic use for a member's medical condition.
 - Durable medical equipment or supplies associated or used in conjunction with medically necessary medical foods and nutritional substances.
 - CareFirst's payment for rental will not exceed the total cost of purchase. CareFirst's payment is limited to the least expensive medically necessary durable medical equipment, adequate to meet the member's medical needs. CareFirst's payment for durable medical equipment includes related charges for handling, delivery, mailing and shipping, and taxes.
- Hair Prosthesis:
 - Benefits are available for a hair prosthesis when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.
- Hearing Aids:
 - Covered services for a minor dependent child, as follows:
 - One hearing aid, prescribed, fitted, and dispensed by a licensed audiologist for each hearing-impaired ear; and
 - Non-routine services related to the dispensing of a covered hearing aid, such as assessment, fitting, orientation, conformity, and evaluation.
- Medical Foods and Nutritional Substances:
 - Medically necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a contracted health care provider qualified to provide the diagnosis and treatment in the field of the disorder/disease, as determined by CareFirst.
- Medical Supplies:
 - Benefits are available for medical supplies as such supplies are defined by CareFirst.
- Orthotic Devices and Prosthetic Devices:
 - Except for a prosthetic leg, arm, or eye, benefits provided for orthotic devices and prosthetic devices include:
 - Supplies and accessories necessary for effective functioning of a covered service;
 - Repairs or adjustments to medically necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and
 - Replacement of medically necessary devices when repairs or adjustments fail and/or are not possible.

- Prosthetic leg, arm, or eye:
 - Coverage shall be provided for an artificial device which replaces, in whole or in part, a leg, an arm, or an eye.
 - Coverage includes:
 - Components of prosthetic leg, arm, or eye; and
 - Repairs to prosthetic leg, arm, or eye.
 - Requirements for medical necessity for coverage of a prosthetic leg, arm, or eye will not be more restrictive than the indications and limitations of coverage and medical necessity established under the medical coverage database.
- Repairs:
 - Benefits for the repair, maintenance, or replacement of a medical device require authorization or approval by CareFirst. Except for benefits for a prosthetic leg, arm, or eye, benefits are limited to:
 - Coverage of maintenance costs is limited to routine servicing, such as testing, cleaning, regulating, and checking of equipment.
 - Coverage of repair costs is limited to adjustment required by normal wear or by a change in the member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the medical device.
 - Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the member or of a family member are not covered.

Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment

- Inpatient/outpatient mental health and substance use disorder services, including behavioral health treatment.

Organ and Tissue Transplants

When Member Is:	Available Benefits
Recipient	Benefits are available for both the member recipient and the non-member donor. Donor services are available only to the extent that benefits are not available from another source, such as other group health plan coverage or health insurance plan.
Donor	No benefits are available.

- Medically necessary, non-experimental/investigational solid organ transplant procedures and bone marrow or other non-solid organ transplant procedures, and related services. Benefits will be provided for high dose chemotherapy/bone marrow or stem cell transplant treatment that is not experimental/investigational as determined by CareFirst.
- Donor services, limited to the extent defined by CareFirst.
- Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant.

- Organ transplant procurement benefits for the recipient, as follows:
 - Health services and supplies used by the surgical team to remove the donor organ.
 - Travel of a hospital surgical team to and from a hospital (other than the organ transplant hospital) where the organ is to be removed from the donor.
 - Transport and storage of the organ, at the organ transplant hospital, in accordance with approved practices.
- Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant is over 50 miles from the recipient's home. Travel is limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. In order to receive travel benefits, a companion must be at least 18 years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under 18 years of age, there may be two companions.
- Additional requirements:
 - The organ transplant hospital must:
 - Have fair and practical rules for choosing recipients and a written contact with someone that has the legal right to procure donor organs;
 - Conform to all laws that apply to organ transplants; and
 - Be approved by CareFirst.
 - At least 30 days before the start of a planned organ transplant, the recipient's physician must give CareFirst written notice including:
 - Proof of medical necessity;
 - Diagnosis;
 - Type of surgery; and
 - Prescribed treatment.

Outpatient Private Duty Nursing

- Benefits are available for medically necessary outpatient private duty nursing, as determined by CareFirst. Benefits are not provided for private duty nursing rendered in a hospital.

Prescription Drugs

- Benefits for prescription drugs, intended for outpatient use, include injectable prescription drugs that require administration by a health care provider. Additional benefits for prescription drugs, intended for outpatient use, are available as follows:

Pharmacy-Dispensed Prescription Drugs	Prescription Drugs Dispensed in the Office of a Health Care Provider
Benefits are not available through CareFirst for pharmacy-dispensed prescription drugs	Benefits are available, and limited to, prescription drugs dispensed in the office of a health care provider. Contraceptives: benefits are available for injectable prescription drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a health care provider, and dispensed in the office of a health care provider.

Professional Nutritional Counseling/Medical Nutrition Therapy

- Benefits are available for professional nutritional counseling, to include medical nutrition therapy services, when medically necessary as determined by CareFirst.

Rehabilitative and Habilitative Services

- Outpatient Rehabilitative Services: benefits are available for the following outpatient rehabilitative services:
 - Occupational therapy;
 - Physical therapy; and
 - Speech therapy.
- Cardiac Rehabilitation: benefits for cardiac rehabilitation are provided to a member who has been diagnosed with significant cardiac disease, as defined by CareFirst, or, who, immediately preceding referral for cardiac rehabilitation, suffered a myocardial infarction or has undergone invasive cardiac treatment, as defined by CareFirst. All services must be medically necessary as determined by CareFirst in order to be covered. Services must be provided at a CareFirst-approved place of service equipped and approved to provide cardiac rehabilitation. Benefits will not be provided for maintenance programs.
- Habilitative Services (dependent child through the end of the month in which the member turns 19 years old): habilitative services are health care services and devices that help a child keep, learn, or improve skills and functioning for daily living.
 - Benefits for habilitative services will be provided for members until at least the end of the month in which the member turns 19 years old.
 - Benefits include occupational therapy, physical therapy, and speech therapy. Habilitative services for autism, or an autism spectrum disorder, include applied behavior analysis services.
- Pulmonary Rehabilitation: benefits are provided to members who have been diagnosed with significant pulmonary disease, as defined by CareFirst, or who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all medically necessary services, as determined by CareFirst. Services must be provided at a CareFirst-approved place of service equipped and approved to provide pulmonary rehabilitation. Benefits will not be provided for maintenance programs.
- Visual Therapy: benefits are available for outpatient visual therapy.

Surgical Treatment of Morbid Obesity

- Benefits are provided for the surgical treatment of morbid obesity. The procedures must be recognized by the NIH as effective for the long-term reversal of morbid obesity and consistent with guidelines approved by the National Institutes of Health (NIH) and deemed medically necessary by CareFirst.

What's Not Covered

CareFirst PPN will not provide a benefit for the following:

- 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.
- Services that are not described as covered services or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if medically necessary, by an in-network health care provider does not, by itself, entitle a member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.

- 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 provided, as determined by CareFirst.
- Services or supplies which: were provided at no charge in any federal hospital, or through any federal, state, or local governmental agency or department; were not your legal obligation; or are only charged to insured people. This exclusion does not apply to:
 - Medicaid;
 - Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland; or
 - Care received in a Veteran’s hospital unless the care is provided for a condition resulting from military service.
- Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be medically necessary), including flat foot conditions, supportive devices, 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.
- Routine dental care such as services, supplies, or charges directly related to the care, restoration, removal or replacement of teeth, the treatment of disease of the teeth, gums, or structures directly supporting or attached to the teeth. (Note that if you are enrolled in a City Schools’ dental plan, these services may be covered under that plan.)
- Cosmetic services (except for mastectomy-related services and services for cleft lip or cleft palate or both).
- Treatment provided by a health care provider who is your parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or who resides in your home.
- All non-prescription drugs, medications, and biologicals routinely obtained and self-administered by you, unless otherwise a covered service.
- All over-the-counter items and supplies, routinely obtained and self-administered by you, including but not limited to: non-prescription eye wear; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and over-the-counter solutions, except for over-the-counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B.”
- Lifestyle improvements, including but not limited to, health education classes and self-help programs unless specifically covered in CareFirst’s description of covered services.
- Fees or charges related to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment other than medically necessary and approved pulmonary and/or cardiac rehabilitation program.
- Treatment for weight reduction and obesity, except for the surgical treatment of morbid obesity and covered services provided under the disease management program. This exclusion does not apply to the treatment of childhood obesity, as required by the Patient Protection and Affordable Care Act.
- Routine eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses. (Note: these services may be covered by the City Schools' vision plan.)
- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy or any other forms of refractive keratoplasty or any complications.
- Service furnished as a referral prohibited by law.

- Any recreational activity intended as a rehabilitative service. This includes, but is not limited to: sports, games, horseback riding, and athletic training, even though such service may have therapeutic value or be provided by a health care provider.
- Non-medical health care provider services, including but not limited to:
 - Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services.
 - Administrative fees charged by a health care provider to a member to retain the health care provider's medical practice service, for example, "concierge fees" or boutique medical practice membership fees.
- Educational therapies intended to improve academic performance.
- Vocational rehabilitation and employment counseling.
- Services related to an excluded service (even if they would otherwise be covered) except general anesthesia and associated hospital or ambulatory surgical facility service for dental care.
- Separate billings for service or supplies provided by an employee of a health care provider which are normally included in the health care provider's charges.
- Non-medical services, including but not limited to: personal hygiene, cosmetic items, and convenience items, including but not limited to, air conditioners, humidifiers, exercise equipment, elevators, and ramps.
- Personal comfort items, even when used in an inpatient hospital setting, such as telephones, televisions, guest trays, and laundry charges.
- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, such as bathing, toileting, and eating (care which may be provided by people without professional medical skills or training).
- Self-care or self-help training designed to help someone cope with a health problem or to modify behavior for improvement of general health, unless otherwise stated.
- Services intended to increase the intelligence quotient (IQ) of a person with an intellectual disability or to provide cure for primary developmental disabilities, if the services do not fall within generally accepted standards of medical care.
- Services for the purpose of controlling or overcoming delinquent, criminal, or socially unacceptable behavior unless deemed medically necessary by CareFirst.
- Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related.
- Services related to human reproduction other than specifically described in the evidence of coverage including, but not limited to maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a member.
- Blood products and whole blood when donated or replaced.
- Oral surgery, dentistry, or dental processes, unless otherwise stated, including removal or replacement of teeth, crowns, bridges, implants, orthodontics except cleft palate, the operation or treatment for the fitting or wearing of dentures, periodontal therapy, direct or indirect restorations (fillings), root canal therapy, treatment of dental cysts and abscesses. (Note that if you are enrolled in one of the City Schools' dental plans, these services may be covered under that plan.)
- Premarital exams.
- Services performed or prescribed by or under the direction of a person who is not a health care provider, or who is acting beyond his/her scope of practice.

- Services provided through a dental or medical department of an employer, a mutual benefit association, a labor union, trust, or similar entity.
- Services provided or available under any workers' compensation or occupational disease, or employer's liability law, or any other similar law, even if you fail to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships, and officers of closed corporations. If a member is exempt from the above laws, the benefits of the evidence of coverage will be provided for covered services.
- Services provided or available through an agent of a school system in response to the requirements of the Individuals with Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are normally covered when provided outside the educational domain.
- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- Exams and related services, and completion of forms, required solely for: employment, pre-employment screening, insurance, foreign travel, travel requirements, school, camp admissions/scouting programs, participation in sports activities (sports physicals), pre-adoption, adoption, pre-foster parenting, foster parenting, admission to old age home, driving license including commercial driving license, handicapped tag documentation, immigration and naturalization, marriage, prison, disability examination, FMLA verification, workers' compensation, attorney forms, or attendance for issue of medical certificates.
- Immunizations solely for foreign travel.
- Charges used to satisfy your dental, prescription drug, or vision plan deductible, if applicable, or balances from any such programs.
- Financial and/or legal services.
- Dietary or nutritional counseling, except as stated in covered services.
- Tinnitus maskers, purchase, examination, or fitting of hearing aids except as stated in the description of covered services.
- Services solely required or sought on the basis of a court order as a condition of parole or probation unless authorized or approved by CareFirst.
- Work hardening programs, which 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.
- Regarding non-emergency ambulance services, the following are excluded: any air transportation; and except for covered ambulance services, travel, including travel required to return to the service area, whether or not recommended by a health care provider. Additional limited travel benefits related to an organ transplant may be covered if stated in the description of covered services.
- Regarding emergency ambulance services, the following are excluded: any air transportation; and except for covered ambulance services, travel whether or not recommended by a health care provider. Additional limited travel benefits related to an organ transplant may be covered if stated in the description of covered services.
- Dental care (even if provided under general anesthesia and the general anesthesia and associated hospital/facility charges are covered).
- Regarding home health care, the following are excluded: rental or purchase of renal dialysis equipment and supplies; Meals-on-Wheels-type food plans; domestic or housekeeping services; care that, after training by skilled personnel, can be provided by a non-health care provider, such as one of the member's family or a friend (for example, changing wound dressings).

- Regarding hospice care, the following are excluded: any services other than palliative treatment; rental or purchase of renal dialysis equipment and supplies; domestic or housekeeping services; Meals-on-Wheels-type food plans.
- Regarding reproductive services, the following are excluded:
 - When the member or spouse has undergone elective sterilization with or without reversal.
 - When any surrogate or gestational carrier is used.
 - When the service involves the use of donor embryo(s).
 - Cryopreservation, storage, and/or thawing of sperm, oocytes, or embryo(s).
 - Cost of donor sperm or donor oocytes.
 - When the spouse is of the opposite sex, when the service involves the use of donor oocytes or donor sperm.
 - When the spouse is of the opposite sex, when the service involves collection of the member's spouse's sperm if the member's spouse is not a member.
 - When the spouse is of the same sex, when the service involves the use of donor oocytes.
 - Self-administered fertility drugs (including over the counter medications) that are neither covered under the prescription drug plan nor listed as a covered service.
- Inpatient stays that are primarily for diagnostic service, observation, and/or rehabilitative services; inpatient private duty nursing; a private room when the hospital has semi-private rooms; allergenic extracts (allergy sera); procedures to reverse sterilization.
- Cranial molding orthoses for positional/deformational/non-synostic plagiocephaly or brachycephaly; durable medical equipment or supplies related to non-covered items or services; orthotic and prosthetic devices except as stated in covered services; food and formula consumed as sole source or supplemental nutrition except as stated in CareFirst's description of covered services.
- Marital counseling, wilderness programs, or boarding schools.
- Organ transplants that are: performed outside the continental United States; due to an employment-related condition; or covered by research funds. The plan also excludes expenses related to finding a suitable donor, such as the National Bone Marrow Registry, search of a population, or mass screening.
- Inpatient rehabilitation services; rehabilitative and habilitative services delivered through early intervention and school services.

Inpatient Pre-Authorization Program

Pre-authorization is required for inpatient hospitalization.

Outpatient Pre-Authorization Program

Certain outpatient services require CareFirst's approval of a plan of treatment before benefits will be paid. You may be subject to a penalty if you do not obtain this approval. The services that require a plan of treatment include:

- Infertility services;
- Home health care;
- Hospice care; and
- Private duty nursing rehabilitation services: occupational therapy, physical therapy, and speech therapy. CareFirst must approve the plan of treatment after the 10th visit.

Claims Payment and Appeals

In-Network Providers

With the PPN plan, when you use an in-network provider, he or she files claims for you.

Out-of-Network Providers

Even if a provider is not in the PPO network, as long as he/she participates with CareFirst (contracts with CareFirst to be paid directly), he or she will file claims for you.

Non-Participating Providers

You must file claims for services you receive from non-participating providers, as they have not contracted to be paid directly by CareFirst. Claims for medical benefits must be submitted within 15 months from the date of service, or as soon as is reasonably possible. CareFirst will process the claim within 30 days of receiving it. The claims mailing address is on the claim form. You can obtain claim forms online at www.carefirst.com.

Out-of-Area Care

CareFirst participates in a program called BlueCard®, which enables you to receive an in-network level of benefits when you are out of your plan's service area. To receive the maximum amount of coverage available, you must receive care from a BlueCard® PPO provider. If you receive care from a provider who is not a BlueCard® PPO provider, generally CareFirst will allow coverage up to CareFirst's allowed benefit. You then pay the difference between CareFirst's allowed benefit and the provider's actual charge.

Appealing a Denied Claim

If your claim is denied and you believe part or all of it should have been paid, you have 180 days from the date of the denial to submit an appeal. You may include additional medical information, comments, records, or other information relating to the claim. Send the appeal with the additional information to:

CareFirst BlueCross BlueShield
National Account Dedicated Service
Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. You will also be permitted to present evidence and testimony as part of the internal claims and appeals process.

CareFirst will respond to your appeal within 60 days of receiving it, unless it is determined that special circumstances require additional time to process the claim. If it is determined that an extension of time for processing is required, you will receive written notice of the extension. In no event will the extension exceed 60 days from the end of the initial 60-day period. You will receive the results of the review in writing.

If your claim is denied after appeal, CareFirst will provide you with notification including:

- The reason why it was denied;
- Reference to the specific plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim;; and
- A statement describing any voluntary appeal procedures available to you.

External Review Process

If your claim is denied after still denied after you appeal the denied claim, you may request an external review of your claim if you file a request for external review within four months after the date you receive the denied benefit determination. Within five business days of receipt of your external review request, CareFirst will complete a preliminary review of your claim. Within one business day after the preliminary review, CareFirst will notify you in writing if the request is not eligible for external review or if it is not complete. If the request is not complete, you will have the opportunity to submit additional information within 48 hours after you receive notification.

CareFirst will assign an Independent Review Organization (IRO) to conduct your external review. The IRO will notify you in writing of the eligibility of your request and acceptance for external review. You have the opportunity to submit any additional information to the IRO within 10 business days following the date you receive notification from the IRO. Within five business days after the IRO is assigned to your external review, CareFirst will provide all documents and information related to your denied appeal to the IRO.

The IRO will provide you with written notice of the final external review decision within 45 days after the IRO receives your request for external review. The notice will include:

- Description of the reason for the external review request;
- The date the IRO was assigned to your external review and the date of the final decision;
- References to evidence or documentation, including specific coverage provisions and evidence-based standards considered in the decision;
- Discussion of the principal reason(s) for its decision;
- Statement that the determination is binding and that judicial review may be available; and
- Contact information for any applicable office of health insurance consumer assistance.

Claim Payment Made in Error

If CareFirst makes a claim payment in error, you are required to repay CareFirst. If you have not repaid the full amount you owe by the time CareFirst pays your next claim, CareFirst may subtract the amount you owe from the next payment.

Assignment of Benefits

You may not assign your right to receive benefits or benefit payments to another person. The only exception is the usual practice of asking CareFirst to pay participating providers directly for services you receive.

CareFirst PPN Definitions

Allowed Benefit

- Preferred health care providers: for a health care provider that has contracted with CareFirst, the allowed benefit for a covered service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date the service is provided. The benefit is payable to the health care provider and is accepted as payment in full, except for any applicable member payment amounts.
- Non-preferred health care providers:
 - For a health care practitioner that has not contracted with CareFirst, the allowed benefit for a covered service is based upon the lesser of the provider's actual charge or established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the subscriber, it is the member's responsibility to pay the health care practitioner. Additionally, the member is responsible for any applicable member payment amounts, as stated in the schedule of benefits, and for the difference between the allowed benefit and the health care practitioner's actual charge.
 - For a hospital or health care facility that has not contracted with CareFirst, the allowed benefit for a covered service is based upon the lower of the provider's actual charge or established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable member payment amounts, as stated in the schedule of benefits. This benefit is payable to the subscriber or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments to the United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the subscriber, it is the member's responsibility to pay the hospital or health care facility. Additionally, the member is responsible for any applicable member payment amounts, as stated in the schedule of benefits and, unless negotiated, for the difference between the allowed benefit and the hospital or health care facility's actual charge.
 - Non-preferred emergency services health care provider: CareFirst shall pay the greater of the following amounts for emergency services received from a non-contracted emergency services health care provider:
 - The allowed benefit stated above.
 - The amount negotiated with preferred health care providers for the emergency service provided, excluding any copayment or coinsurance that would be imposed if the service had been received from a contracted emergency services health care provider. If there is more than one amount negotiated with preferred health care providers for the emergency service provided, the amount paid shall be the median of these negotiated amounts, excluding any copayment or coinsurance that would be imposed if the service had been received from a contracted emergency services health care provider.

- The amount for the emergency service calculated using the same method CareFirst generally used to determine payments for services provided by a non-preferred health care provider, excluding any copayment or coinsurance that would be imposed if the service had been received from a contracted emergency services health care provider.
- The amount that would be paid under Medicare for the emergency service, excluding any copayment or coinsurance that would be imposed if the service had been received from a contracted emergency services health care provider.

Adverse Decision – a utilization review determination that a proposed or delivered health care service covered under your contract is or was not medically necessary, appropriate, or efficient; and may result in non-coverage of the health care service.

Ancillary Services – facility services that may be provided inpatient and/or outpatient. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, durable medical equipment, and medical supplies. Ancillary services do not include room and board services billed by a facility for inpatient care.

Applied Behavior Analysis – the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Benefit Period – the period of time during which covered services are eligible for payment. The benefit period is January 1st through December 31st.

Body Mass Index (BMI) – a practical marker used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Cardiac Rehabilitation – inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process, and enhance the psychosocial and vocational status of eligible members.

CareFirst – CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield.

Caregiver – a person who is not a health care provider who lives with or is the primary caregiver of the member in the home. The caregiver can be a relative by blood, marriage, or adoption, or a friend of the member, but cannot be a person who normally charges for giving services. However, at CareFirst's discretion, a caregiver may be an employee of a hospice care hospital/agency.

Claims Administrator – CareFirst.

Coinsurance – the percentage of the allowed benefit allocated between CareFirst and the member whereby CareFirst and the member share in the payment for covered services.

Contracted Health Care Provider – for purposes of inter-plan ancillary services, a health care provider who has contracted with the local BlueCross and/or BlueShield Licensee (not CareFirst) and provides ancillary services to the member outside of the CareFirst service area.

Controlled Clinical Trial – a treatment that is:

- Approved by an institutional review board;
- Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and
- Is approved by:
 - The National Institutes of Health (NIH) or a Cooperative Group.
 - The Centers for Disease Control and Prevention.
 - The Agency for Health Care Research and Quality.
 - The Centers for Medicare & Medicaid Services.
 - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs.
 - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
 - The Department of Veterans Affairs, the Department of Defense or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that has been determined:
 - To be comparable to the system of peer review of studies and investigations used by the NIH; and
 - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - The FDA in the form of an investigational new drug application.
 - An institutional review board of an institution in a state that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH.

Convenience Item – any item that increases physical comfort or convenience without serving a medically necessary purpose, for example, elevators, hoist/stair lifts, ramps, shower/bath bench, and items available without a prescription.

Cooperative Group – a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative group includes the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the Aids Clinical Trials Group; and the Community Programs For Clinical Research in Aids.

Copayment (copay) – a fixed dollar amount that a member must pay for certain covered services. When a member receives multiple services on the same day by the same health care provider, the member will only be responsible for one copay.

Cosmetic – the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Covered Service – a medically necessary service or supply provided according to the terms of CareFirst's evidence of coverage.

Deductible – the dollar amount of covered services based on the allowed benefit, which must be incurred before CareFirst will pay for all or part of remaining covered services. The deductible is met when the member receives covered services that are subject to the deductible and pays for these him/herself.

Dependent – a member who is covered under the plan as your eligible spouse or eligible child.

Donor Services – services covered under the evidence of coverage which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure, which are directly related to donating the organ or tissue.

Durable Medical Equipment – equipment which:

- Is primarily and customarily used to serve a medical purpose;
- Is not useful to a person in the absence of illness or injury;
- Is ordered or prescribed by a physician or other qualified practitioner;
- Is consistent with the diagnosis;
- Is appropriate for use in the home;
- Is reusable; and
- Can withstand repeated use.

Effective Date – the date on which the member's coverage becomes effective. Covered services rendered on or after the member's effective date are eligible for coverage.

Emergency Medical Condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services – with respect to an emergency medical condition:

- A medical screening examination that is within the capability of the emergency department of a hospital or in an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition;
- Items and services for which benefits are provided or covered under the plan or coverage and that are furnished by a nonparticipating provider or nonparticipating emergency facility, regardless of the department of the hospital in which such items or services are furnished, after the participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the emergency visit; and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the member, as defined in the Social Security Act.

Essential Health Benefits – as defined by the Patient Protection and Affordable Care Act, includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Evidence of Coverage – the agreement between the City Schools and CareFirst that describes the details of the plan.

Experimental/Investigational – a service or supply that is in the developmental stage and in the process of human or animal testing excluding Clinical Trial Patient Cost Coverage as stated in CareFirst’s description of covered services. Services or supplies that do not meet all five of the criteria listed below:

- The Technology* must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
- The Technology must improve the net health outcome;
- The Technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside the investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

FDA – the Federal Food and Drug Administration.

Group – the subscriber’s employer/plan sponsor or other organization to which CareFirst has issued the group contract and evidence of coverage.

Group Contract – the agreement issued by CareFirst to the group through which the benefits described in the evidence of coverage are made available. In addition to the evidence of coverage, the group contract includes any riders and/or amendments attached to the group contract or evidence of coverage and signed by an office of CareFirst.

Habilitative Services – health care services and devices, including but not limited to, occupational therapy, physical therapy, and speech therapy that help a child keep, learn, or improve skills and functioning for daily living.

Health Care Provider – a hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide covered services.

Hearing Aid – a device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children and is non-disposable.

Home Health Care – the continued care and treatment of a member by a health care provider in the home if:

- The member is under the care of the PCP or the contracted health care provider;
- The member’s physician establishes and approves in writing the plan of treatment recommending the home health care services; and
- Institutionalization of the member would have been required and deemed medically necessary by CareFirst if the home health care was not provided.

Home Health Care Visit:

- Each visit by a member of a home health care team is considered one home health care visit; and
- Up to four hours of home health care service is considered one home health care visit.

Hospice Care Program – a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement.

Incurred – a member’s receipt of a health care service or supply for which a charge was made.

Infusion Therapy – treatment that places therapeutic agents into the vein, including intravenous feeding.

Lifetime Maximum – the maximum dollar amount payable toward a member’s claims for covered services while the member is covered under this group contract. Essential health benefits covered services are not subject to the lifetime maximum.

Limiting Age – the maximum age to which an eligible child may be covered under the plan.

Medical Device – durable medical equipment, hearing aid, medical supplies, orthotic devices, and prosthetic devices.

Medical Director – a board certified physician who is appointed by CareFirst. The duties of the medical director may be delegated to qualified persons.

Medically Necessary or Medical Necessity – health care services or supplies that a health care provider, exercising prudent 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 or supplies are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for a patient’s illness, injury, or disease;
- Not primarily for the convenience of a patient or health care provider; and
- 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.

Medical Nutritional Therapy – provided by a registered dietitian, involves the assessment of the member’s overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition such as cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizure disorders (e.g., ketogenic diet), and other conditions based on the efficacy of diet and lifestyle on the treatment of these disease states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a member’s food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

Medical Supplies – items that:

- Are primarily and customarily used to serve a medical purpose;
- Are not useful to a person in the absence of illness or injury;
- Are ordered or prescribed by a physician or other qualified practitioner;
- Are consistent with the diagnosis;
- Are appropriate for use in the home;
- Cannot withstand repeated use; and
- Are usually disposable in nature.

Medically Necessary or Medical Necessity – health care services or supplies that a health care provider, exercising prudent clinical judgment, provides 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 or supplies are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for a patient’s illness, injury, or disease;
- Not primarily for the convenience of a patient or health care provider;
- Not more costly than an alternative service or frequency of service 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.

Member – an individual who meets all applicable eligibility requirements, is enrolled either as a subscriber or dependent, and for whom payment has been received by CareFirst.

Morbid Obesity –

- A body mass index that is greater than 40 kilograms per meter squared; or
- Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

Multiple Project Assurance Contract – a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

Non-Contracted Health Care Provider – for purposes of the inter-plan ancillary services section of this evidence of coverage, a health care provider that does not contract with the local BlueCross and/or BlueShield Licensee (not CareFirst) and provides ancillary services to the member outside of the CareFirst service area, as stated in the inter-plan ancillary services section.

Non-Preferred Health Care Provider – any health care provider that is not a preferred provider.

Occupational Therapy – 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 who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition.

Open Enrollment – a single period of time each year during which you can change coverage or enroll in coverage. For City Schools’ employees, open enrollment is held during the fall of each year, for an effective date of January 1 of the following year.

Orthotic Device – orthoses and braces which:

- Are primarily and customarily used to serve a therapeutic medical purpose;
- Are prescribed by a health care provider;
- Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;
- May be purely passive support or may make use of spring devices; and
- Includes devices necessary for post-operative healing.

Out-of-Pocket Maximum – the maximum amount the member will have to pay for his/her share of benefits in any benefit period.

Over-the-Counter – any item or supply, as determined by CareFirst, that is available for purchase without a prescription, unless otherwise a covered service. This includes, but is not limited to, nonprescription 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.

Paid Claims – the amount paid by CareFirst for covered services. Inter-plan arrangement fees and compensation are also included in paid claims. Other payments relating to fees and programs applicable to CareFirst's role as claims administrator may also be included in paid claims.

Patient Cost – the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial. Patient cost does not include the cost of an investigational drug or device, the cost of non-health care services that a member may be required to receive as a result of the treatment being provided for purposes of the clinical trial, costs associated with managing the research associated with the clinical trial, or costs that would not be covered under this evidence of coverage for non-investigational treatments.

Physical Therapy – the short-term treatment described below that can be expected to improve a condition. Physical Therapy is the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Plan – the portion of the group health plan established by the group that provides for health care benefits for which CareFirst is the claims administrator under this group contract.

Plan of Treatment – the plan written and given to CareFirst by the attending health care provider on CareFirst forms which shows the member's diagnoses and needed treatment.

Preferred Provider – a health care provider who contracts with CareFirst to be paid directly for rendering covered services to members. The contracted preferred provider has the obligation of referring members within the network. Preferred provider relates only to method of payment and does not imply that any health care provider is more or less qualified than another.

Prescription Drug:

- A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend “may not be dispensed without a prescription.”
- Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.
- Prescription drugs do not include:
 - Compounded bulk powders that contain ingredients that:
 - Do not have FDA approval for the route of administration being compounded;
 - Have no clinical evidence demonstrating safety and efficacy; or
 - Do not require a prescription to be dispensed.
 - Compounded drugs that are available as a similar commercially available prescription drug, unless:
 - There is no commercially available bio-equivalent prescription drug; or
 - The commercially available bio-equivalent prescription drug has caused or is likely to cause the member to have an adverse reaction.

Private Duty Nursing – skilled nursing care that is not rendered in a hospital/skilled nursing facility.

Professional Nutritional Counseling – individualized advice and guidance given to a member at nutritional risk due to nutritional history, current dietary intake, medication use, or chronic illness, about options and methods for improving nutritional status. Professional nutritional counseling must be provided by a registered licensed dietitian or other eligible health care provider, as determined by CareFirst.

Prosthetic Device – a device which:

- Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or
- Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
- Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
- Is prescribed by a health care provider; and
- Is removable and attached externally to the body.

Rehabilitative Services – includes physical therapy, occupational therapy, and speech therapy for the treatment of individuals who have sustained an illness. The goal is to return the individual to his/her prior skill set and functional level.

Related Services – services or supplies for, or related to, organ/tissue transplant procedures, including but not limited to: diagnostic services, inpatient/outpatient health care provider services, prescription drugs, surgical services, occupational therapy, physical therapy, and speech therapy.

Rescission – a cancellation or discontinuance of coverage that has a retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual’s or group’s enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effectively retroactively to the extent it is attributable to a failure to timely pay charges when due by the group.

Respite Care – short-term care for a member that provides relief to the caregiver.

Service Area – CareFirst’s service area, a clearly defined geographic area in which CareFirst has arranged for the provision of health care services to be generally available and readily accessible to members.

Skilled Nursing Care – depending on the place of service or benefit:

- Inpatient hospital/facility or skilled nursing facility:
 - Skilled nursing care rendered on an inpatient basis, means care for medically fragile members with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the member’s safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week.
- Skilled nursing care provided in the home:
 - Medically necessary skilled care services performed by a licensed registered nurse (RN) or licensed practical nurse (LPN).
 - Skilled nursing care home visits must be a substitute for hospital care or for care in a skilled nursing facility (i.e., if the visits were not provided, the member would have to be admitted to a hospital or skilled nursing facility).
 - Service of a home health aide, medical social worker, or registered dietician performed under the supervision of a licensed professional (RN or LPN) nurse.
 - Skilled nursing care services in a home health care setting must be based on a plan of treatment submitted by a health care provider.
- Outpatient private duty nursing:
 - Medically necessary skilled care services performed by a licensed registered nurse (RN) or licensed practical nurse (LPN).
 - Skilled nursing care must be a substitute for hospital care or for care in a skilled nursing facility (i.e., if the visits were not provided, the member would have to be admitted to a hospital or skilled nursing facility).
 - Skilled nursing care must be ordered by a physician and based on plan of treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.

Skilled nursing care is not medically necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the activities of daily living (ADL), including but not limited to, bathing, feeding, and toileting is not skilled nursing care.

Skilled Nursing Facility – a licensed institution (or distinct part of a hospital) that provides continuous skilled nursing care and related services if you need medical care, skilled nursing care, or rehabilitative services.

Sound Natural Teeth – teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) and excludes any tooth replaced by artificial means (fixed or removable bridges, or dentures).

Specialist – a physician who is certified or trained in a specified field of medicine.

Specialty Drug – prescription drugs which include, but are not limited to, drugs that are very expensive, large molecule, high potential for adverse effects, have stability concerns requiring special handling, and/or are often derived from biologic processes rather than chemical processes. These drugs are often highly effective when used according to a strict administration regimen and therefore may require support and management services.

Speech Therapy – the treatment of communication impairment and swallowing disorders. Speech therapy facilitates the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Subscriber – a member who is covered under this evidence of coverage as an eligible employee or eligible participant of the group, rather than as a dependent.

Type of Coverage – either individual coverage, which covers the subscriber only, or family coverage, under which a subscriber may also enroll his or her dependents. Some group contracts include additional categories of coverage, such as individual and adult and individual and child. The types of coverage available under this evidence of coverage are individual, individual and child, individual and adult, family.

Note: If both the subscriber and dependent spouse qualify as “subscribers” of the group, they may not enroll under separate individual type of coverage memberships, i.e., as separate “subscribers.”

Urgent Care – treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the hospital emergency room. An urgent care facility is a free-standing facility that is not a physician’s office and which provides urgent care.

Waiting Period – the period of time that must pass before an employee or dependent is eligible to enroll under the terms of group of the group health plan. A waiting period determined by the group may not exceed the limits required by applicable federal law and regulation.

For More Information

For more information about the CareFirst PPN plan, visit CareFirst’s website at www.carefirst.com, or call CareFirst at 410-581-3506 or toll-free at 1-800-648-5285.

Kaiser Permanente Health Maintenance Organization (HMO)

The Kaiser Permanente HMO is administered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. The plan is a network model health maintenance organization (HMO). With the HMO plan, you benefit from Kaiser's traditional HMO network.

How the Plan Works

Care from Kaiser Network Providers and Facilities

To receive any benefits under the plan, you must:

- Receive care from a primary care physician (PCP) in Kaiser's network within the service area.
- Get authorized referrals to specialists from your PCP.
- Get referrals for hospital care and other inpatient care (for example, a skilled nursing facility) in one of Kaiser's network hospitals/facilities.
- Receive lab, radiology, and other specialty services through a Kaiser network facility. Note: Prescription benefits are provided through a separate plan, administered by Express Scripts. With this plan, there is no "out-of-network" care; however, you are covered for emergency and urgent care services anywhere in the world. In addition, benefits are available through other Kaiser regions if you are temporarily away from the service area. For more details, visit Kaiser's website, www.kp.org or contact Kaiser at 301-468-6000 or toll-free at 1-800-777-7902.

Your Primary Care Physician

With the Kaiser HMO plan, you choose a primary care physician (PCP) in the plan's service area. Your PCP will provide most of your routine care and refer you to specialists when needed. PCPs practice in the areas of pediatrics, internal medicine, and family practice. By establishing a relationship with your own primary care physician, you ensure a medical professional is taking a vested interest in your wellbeing. Primary care physicians offer personalized health care services. They review your medical background, take the time to understand your health goals, and coordinate your health care needs, including hospital or specialty care.

How to Select a Primary Care Physician

When you enroll, you will select a primary care physician for you and each of your family members. If you do not select a PCP, the plan will select one for you based on where you live. You may change your primary care physician any time you like, for any reason, by calling the Kaiser Member Services number on the back of your ID card. You may choose your PCP from among Kaiser's doctors in the Mid-Atlantic Permanente Medical Group (MAPMG), who practice exclusively at Kaiser's medical centers. You may choose a primary care physician who practices near your work or home. You may select one PCP for your whole family, or a different PCP for each family member. PCPs and other plan providers are listed online. You may also call a member services representative who will offer suggestions based on your specific needs. Call 301-468-6000 or 1-800-777-7902 (toll-free).

Service Area

For a medical service to be covered, you must receive care from plan providers, hospitals, and facilities within Kaiser's service area. This does not apply to:

- Emergency care;
- Urgent care services outside of the service area;
- Authorized referrals; and
- Covered services you receive in other Kaiser Permanente regions.

Note that you are covered for urgent and emergency care anywhere in the world. If you do receive care outside of the Mid-Atlantic area, you will need to submit your bill to Kaiser's claims department for reimbursement or payment.

Identification Cards

After you enroll, your member identification card will arrive in the mail. If, for some reason, you do not receive your card before your effective date, you are still eligible to receive all the benefits that come with your Kaiser membership. Your ID card will have a membership number printed on it. You will use this number when you call for advice, make an appointment, or go to a doctor for care. To ensure that you receive the maximum benefits under the plan, be sure to show your ID card when you receive health care services.

Note: If you let anyone else use your ID card, the health plan may keep your card and terminate your membership.

Referrals

Kaiser's HMO plan providers offer primary medical, pediatric, and obstetrics/gynecology care, as well as specialty care in areas such as general surgery, orthopedic surgery, and dermatology. If your primary care physician decides, in consultation with you, that you require covered services from a specialist, you will be referred to a plan provider who is a specialist in your service area that can provide the care you need.

Services That Do Not Require a Referral

Certain services do not require a referral; however, you must obtain the care from a plan provider for your services to be covered. These services include:

- Chemical dependency and mental health services. However, you must contact the Behavioral Health Access Unit for help with arranging for and scheduling your services. Call 1-866-530-8778 for assistance.
- Medically necessary obstetric and gynecological services, including care provided by a certified nurse-midwife or any other in-plan provider authorized to provide obstetric and gynecological care.
- Optometry services.
- Urgent care services provided inside of Kaiser's service area.

Referrals to Non-Plan Specialists

If your PCP decides that you require covered services not available within Kaiser's network, he or she will refer you to a non-plan provider (inside or outside of the service area). You must have an approved written referral to the non-plan provider in order for Kaiser to cover the services. Copayments, coinsurance, and deductibles for approved referral services are the same as those required for services provided by a plan provider.

Hospital Referrals

If you need hospital care, your plan physician will refer you to a hospital where your doctor has admitting privileges in Kaiser's network. For the current list of plan hospitals, facilities, and providers, visit www.kp.org or call the member services department for a provider directory.

Standing Referrals

If you or your dependent suffer from a life-threatening, degenerative, chronic, or disabling disease or condition that requires specialized care, your primary care physician may determine, in consultation with you and the specialist, that your needs would be best served through the continued care of a specialist. If this applies, your PCP will provide a “standing referral” to a specialist. You, your specialist, and your PCP will develop a written treatment plan. The treatment plan may limit the number of visits to the specialist for the period of time in which visits to the specialist are authorized. The health plan has the right to require your specialist to provide your primary care physician with ongoing communication about your treatment and health status. In the case of pregnancy, after you receive a standing referral from your PCP, your obstetrician is responsible for the primary management of the pregnancy. This means your obstetrician will manage your care and provide any referrals according to the health plan’s policies and procedures (through the postpartum period).

24-Hour Medical Advice

If your primary care physician practices at a Kaiser medical center, registered nurses are available by phone, 24 hours a day, to handle urgent as well as routine medical questions. The advice nurses can help you solve a problem over the phone and instruct you on self-care at home if appropriate. If the problem is more severe and you need an appointment, they will help you get one.

About Kaiser’s Medical Centers

Many Kaiser members choose to receive care at a Kaiser medical center because most services – including laboratory and radiology – are in the same location. These services may vary from medical center to medical center. In general, the Kaiser medical centers have the following services onsite:

- Pediatrics;
- Internal medicine;
- Family practice;
- Obstetrics and gynecology;
- Specialty services, such as dermatology and allergy;
- Laboratory, x-ray, and pharmacy;
- Vision and optical; and
- Member services.

In addition, receive care from a Kaiser Permanente doctor who practices in one of the medical centers and have access to your personal health information online.

After Hours and Urgent Care

For urgent care services – such as a sudden rash, high fever, severe vomiting, ear infection, or a sprain – you may call one of the advice nurses. Kaiser has ten urgent care, after-hours medical centers that are open during evenings, weekends, and holidays. If your primary care physician does not practice in a Kaiser medical center, contact your physician’s office directly. If no one is available, call the medical advice line to speak with a registered nurse. Also, Kaiser Permanente has a network of urgent care facilities for after hour emergencies located throughout Maryland, D.C., and Virginia.

Emergency Care

If you have a medical emergency, call 911 immediately or go to the nearest emergency room. If you are not sure if the situation requires an emergency room visit, and your primary care physician practices at a Kaiser medical center, call the medical advice line (listed on the back of your ID card).

You are covered for urgent and emergency care anywhere in the world. If you (or a family member) receive emergency care outside of a Kaiser Permanente medical center, contact Kaiser within 48 hours of the emergency. The Health Plan will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a different facility. If you (or someone on your behalf) does not notify the health plan, or if you choose not to be transferred, your health care services will not be covered after transfer would have been possible. Remember, if you receive care outside of the Mid-Atlantic service area, you must submit bills to Kaiser's claims department for reimbursement or payment.

Continuing Treatment Following Emergency Services

This chart describes how follow-up care is handled following emergency care.

If You:	Then:
Received emergency services inside of the service area	All continuing or follow-up treatment must be provided or coordinated by your primary care physician in the plan
Received emergency services while temporarily in another Kaiser Permanente region	Continuing or follow-up treatment is available from physicians who contract with that Kaiser Permanente plan
Received emergency services outside of the service area	All continuing or follow-up treatment must be authorized by the plan, until you can safely return to the service area (procedures for care after emergency surgery differ; see next row)
Had emergency surgery	If the plan authorized, directed, referred, or otherwise allowed you to access a hospital emergency facility or other urgent care facility for a condition that required emergency surgery, the plan pays for follow-up care that is medically necessary, directly related to the condition for which the surgery was performed, and provided in consultation with your primary care physician

A Note about Transportation

If you obtain prior approval from the plan, or from the nearest Kaiser Foundation Health Plan Region, the plan will cover necessary ambulance services or other special transportation arrangements medically required to transport you to a plan hospital or medical office in a Kaiser service area, or in the nearest Kaiser Foundation Health Plan Region for continuing or follow-up treatment.

Care in Another Service Area – Visiting Members

If you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily (no more than 90 days), you can receive visiting member care from designated providers in that area. The 90-day limit does not apply to a dependent child who attends an accredited college or vocational school. The covered services, copayment, coinsurance, and deductible may differ from those in your service area. For more information, contact member services. Also, be sure to review your evidence of coverage for a list of covered services and exclusions that apply to visiting member care.

Second Surgical Opinion

A second medical opinion from a plan physician is covered upon request.

Emphasis on Preventive Care

The Kaiser Permanente philosophy is that preventing illness and disease is key to a healthy life; that's why the plan covers care, screenings, programs, and other aspects of preventive care. Kaiser encourages its members to consider diet exercise, relaxation, work, family life, and finding a balance to keep you healthy. Below is a summary of some of the preventive care services available to you as a member:

- Discount fitness club memberships;
- Discounts on Weight Watcher's membership;
- Online walking programs;
- Discounts on massage therapy;
- Online programs to help you manage stress and quit smoking;
- Chiropractic care;
- Acupuncture and other complementary treatments; and
- At kp.org, health assessments, health calculators, health encyclopedia, and more.

What's Covered

The Kaiser Permanente HMO provides coverage for a variety of services and supplies when medically necessary. Keep in mind that other limits and exclusions may apply. If there are any discrepancies between this description and the official plan documents, the official plan documents will determine benefits.

Remember, the plan will not cover any services provided by a non-plan provider, except for:

- Emergency services;
- Urgent care outside of the service area;
- Authorized referrals; and
- Care in other health plan regions.

The services listed below are covered only if all of the following conditions are met:

- A plan physician determines that the services are medically necessary to prevent, diagnose, or treat a medical condition; and
- The services are provided, prescribed, authorized, or directed by a plan physician; and
- You receive the services at a plan facility or skilled nursing facility, and inside of Kaiser's service area; and
- You have met any deductible requirement (see the table at the beginning of this section or contact the plan).

What's Covered (if all of the above conditions are met, as well as other conditions outlined in the group evidence of coverage)

- Accidental dental injury services provided within 12 months of the injury, including restorative services necessary to promptly repair, but not replace, sound natural teeth that have been injured as the result of an external force. To be covered, you must report the accident to your primary care physician within 72 hours of the accident. Other conditions must be met for these services to be covered, as outlined in your group evidence of coverage.
- Allergy services, including evaluations, treatment, injections, and serum.
- Alternative medicine services when deemed medically necessary and prescribed by a primary care plan physician in consultation with Kaiser Permanente's Complementary Alternative Medicine Department, for chronic pain management or chronic illness management (up to 20 visits per contract year) including:
 - Acupuncture services; and
 - Chiropractic services.
- Ambulance services inside the service area, only if:
 - Your condition requires either the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and
 - A plan provider has ordered the ambulance transportation.

Ambulance coverage is also provided for medically necessary transportation or services provided as the result of a 911 call. Your cost share will apply to each encounter, whether or not transport was required.
- Anesthesia for dental services, including general anesthesia and hospital or ambulatory facility services for dental care provided to members who meet certain criteria (age limits and other conditions apply as outlined in your group evidence of coverage).
- Blood, blood products, both derivatives and components, including the collection and storage of autologous blood for elective surgery, as well as:
 - Cord blood procurement and storage for approved medically necessary care (when authorized by a plan provider);
 - The administration of blood and blood products; and
 - Purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other bleeding disorders.
- Diabetic equipment, supplies, and outpatient self-management training and educational services when purchased at a plan pharmacy, including insulin pumps, blood/urine testing agents, and disposable needles and syringes (insulin is covered under a separate prescription drug plan, administered by Express Scripts).
- Dialysis services related to acute renal failure and chronic, end-stage renal disease, if all criteria are met as outlined in the evidence of coverage, including renal dialysis services, self-dialysis services, and home dialysis. Drugs, supplies, and supplements that require administration or observation by medical personnel and are administered to you during a covered stay in a plan hospital or skilled nursing facility, or in a plan medical office or during home visits. These may include drugs, injectables, and radioactive materials used for therapeutic purposes, dressings and casts, and vaccines and immunizations approved by the FDA that are not considered part of routine preventive care.

- Durable medical equipment, limited to the standard item of equipment that adequately meets your medical needs, prescribed by a plan provider for use in your home or during a covered stay in a plan hospital or skilled nursing facility. Home equipment may include oxygen and equipment, positive airway pressure equipment, apnea monitors and bilirubin lights for infants, and asthma equipment.
- Emergency services anywhere in the world.
 - Inside the service area: reasonable charges for emergency services are covered whether they are provided within the Kaiser service area by a plan provider or a non-plan provider. Coverage provided by a non-plan provider is limited to emergency services required before you can, without medically harmful consequences, be transported to a plan hospital or your primary care physician's office.
 - Outside of the service area: reasonable charges for emergency services are covered if you are injured or become ill while temporarily outside of Kaiser's service area.
- External prosthetic and orthotic devices:
 - External prosthetic devices (other than dental) that replace all or part of the function of a permanently inoperative or malfunctioning body part (for example, prosthetic lenses, artificial legs, arms, and eyes).
 - Rigid and semi-rigid external orthotic devices that are used for supporting a weak or deformed body member, or for restricting or eliminating motion in a diseased or injured part of the body (for example, leg, arm, back, and neck braces; therapeutic shoes and inserts for severe diabetic foot disease only).
- Family planning services, including counseling (i.e., birth control information and pre-abortion and post-abortion counseling), tubal ligations, vasectomies, and voluntary termination of pregnancy.
- Habilitative services: medically necessary speech, occupational, and physical therapy for children under age 19 with a congenital or genetic birth defect (such as autism or cerebral palsy), to enhance the child's ability to function.
- Hearing services, such as hearing tests to determine the need for hearing correction, and hearing aids for children under age 18 (up to \$1,400 per hearing aid every 36 months for each hearing impaired ear).
- Home health care services, only within the Kaiser service area, if you are substantially confined to your home and if a plan physician determines that it is feasible to maintain effective supervision and control of care in your home, including:
 - Skilled nursing care;
 - Home health aide services; and
 - Medical social services.
- Hospice care benefits for a terminally ill member (prognosis by a plan physician of six months or less). You can choose hospice services through home or inpatient care instead of traditional services otherwise provided for your illness. The following are covered only within the Kaiser service area:
 - Nursing and physician care;
 - Physical, occupational, speech, and respiratory therapy;
 - Medical social services;
 - Home health aide and homemaker services;
 - Short-term inpatient care (at least 30 days);
 - Respite care (at least 14 days), that may be limited to 5 consecutive days for any one inpatient stay; and
 - Counseling services, including dietary counseling and bereavement counseling.

- Hospital inpatient care in a plan hospital, when the services are generally and customarily provided by an acute care general hospital in the Kaiser service area, including:
 - Room and board, including private room when medically necessary;
 - Specialized care and critical care units;
 - General and specialized nursing care;
 - Operating and recovery room;
 - Plan physicians' and surgeons' services, including consultation and treatment by specialists;
 - Anesthesia;
 - Medical supplies;
 - Chemotherapy and radiation therapy;
 - Respiratory therapy; and
 - Medical social services and discharge planning.
- Infertility services, if certain criteria are met as outlined in the evidence of coverage:
 - Services for the diagnosis and treatment of involuntary infertility females and males;
 - Artificial insemination; and
 - In-vitro fertilization (limited to 3 attempts per live birth, up to a maximum lifetime benefit of \$100,000).
- Inpatient and outpatient services arising from orthodontics, oral surgery, and otologic, audiological, and speech/language treatment as the result of the congenital defect known as cleft lip, cleft palate, or both.
- Mastectomy-related services, including:
 - Reconstruction of the breast on which the mastectomy has been performed.
 - Surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance following a mastectomy.
 - Prostheses and treatment for physical complications from all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes), as determined in consultation with the attending physician and the patient.
 - This coverage is subject to the same annual deductibles and coinsurance provisions that apply to other covered services.
- Maternity services, including:
 - All prenatal visits, childbirth and delivery, and the first postpartum visit with plan providers.
 - Inpatient hospital services for the mother or newborn child, for a minimum of 48 hours after an uncomplicated birth or 96 hours after an uncomplicated cesarean section. (Note: You may request a shorter length of stay in consultation with your doctor. In this case, the plan covers one home health visit within 24 hours of discharge, and an additional home visit if prescribed by the attending provider.)
 - Up to four additional days of hospitalization for the newborn is covered when the mother is required to remain in the hospital for medical reasons.
 - Postpartum home care visit upon release, when prescribed by the attending provider.
 - Medical foods and low protein modified food products for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry.

- Mental illness, emotional disorders, and drug and alcohol abuse services for conditions that (in the option of the plan provider) would be medically necessary and treatable, including:
 - While an inpatient in a licensed or certified facility or program, medical services of physicians and other health professionals, such as individual or group therapy, drug therapy, education, psychiatric nursing care, and appropriate hospital services. Note that medical services for detoxification are limited to the removal of the toxic substance or substances from the system.
 - While in an outpatient setting, necessary services of physicians and other health care professionals to treat mental illness, emotional disorders, and drug and alcohol abuse (as performed, prescribed, or directed by a physician), including evaluations, crisis intervention, individual and group therapy, testing for diagnostic purposes, medical treatment for withdrawal symptoms, and visits for monitoring drug therapy.
- Morbid obesity services, including diagnosis and surgical treatment of morbid obesity that is recognized by the National Institutes of Health as effective for long-term reversal and consistent with guidelines approved by the National Institutes of Health.
- Oral surgery:
 - Treatment of tumors where a biopsy is needed for pathological reasons.
 - Treatment of significant congenital defects causing functional impairment, found in the oral cavity or jaw area.
 - Fractures of the jaw or facial bones.
 - Removal of cysts of non-dental origin or tumors.
 - Surgical correction of malformation of the jaw, when the malformation causes significant impairment of speech and nutrition.
- Outpatient care for preventive medicine, diagnosis, and treatment, including:
 - Primary care visits for internal medicine, family practice, pediatrics, and obstetrics and gynecology.
 - Specialty care visits.
 - Consultations and immunizations for foreign travel.
 - Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting (for example, prostate antigen tests, colorectal cancer screening, bone mass measurement, etc.).
 - Outpatient surgery.
 - Anesthesia.
 - Chemotherapy and radiation therapy.
 - Respiratory therapy.
 - Medical social services.
 - House calls when care can best be provided in your home as determined by a plan provider.
 - After hours urgent care received after the regularly scheduled hours of the plan provider or plan facility.
- Patient costs for clinical trials provided on an inpatient or outpatient basis as the result of treatment for a life-threatening condition or prevention, early detection, and treatment studies on cancer. “Patient costs” mean the cost of medically necessary service that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial. See your evidence of coverage for a list of qualifications and exclusions.

- Preventive care, according to national preventive health care standards and plan guidelines, including:
 - Routine physical exams and health screening testing appropriate to your age and sex.
 - Well-woman exams.
 - Well child care exams.
 - Routine and necessary immunizations (excluding travel) for children and adults according to plan guidelines.
 - An annual pap smear.
 - Mammography screening (by low-dose mammography) to determine the presence of breast cancer. One baseline screening for a member age 35 to 39; one screening every 24 months for a member age 40 – 49; one screening every 12 months for a member age 50 or over.
 - Bone mass measurement to determine risk for osteoporosis.
 - Prostate cancer screening for men age 40 or older.
 - Reconstructive surgery to:
 - Correct a significant disfigurement resulting from an injury or medically necessary surgery.
 - Correct a congenital defect, disease, or anomaly to produce significant improvement in physical function.
 - Treat congenital hemangioma (port wine stains) on the face of members age 18 or younger.
 - For reconstructive surgery following mastectomy, see the section on mastectomy-related services.
 - Colorectal cancer screening, according to the latest guidelines issued by the American Cancer Society.
 - Cholesterol tests (lipid profile).
 - Diabetes screening (fasting blood glucose test).
 - Sexually transmitted disease tests according to plan guidelines, including:
 - Annual chlamydia screening for females under age 20 if sexually active and at least age 20 if they have multiple risk factors; and for male members who have multiple risk factors.
 - Human papillomavirus (HPV) screening according to guidelines recommended by the American College of Obstetricians and Gynecologists.
 - HIV tests.
 - TB tests.
 - Hearing loss screenings for newborns provided by hospital before discharge.
 - Associated preventive care radiological and lab tests not listed above.
- Prosthetic devices, including:
 - Internally implanted devices implanted during surgery, including pacemakers and artificial hips and joints.
 - Ostomy and urological supplies when prescribed by a plan provider and your medical condition meets the health plan's criteria for medical necessity.
 - Breast prostheses (including prostheses for the non-diseased breast to achieve symmetry) and two mastectomy bras per year following a medically necessary mastectomy.
 - One hair prosthesis per course of chemotherapy and/or radiation therapy for a member whose hair loss results from chemotherapy or radiation treatment for cancer (up to a maximum benefit of \$350 per prosthesis).

- Psychiatric residential crisis services that are:
 - Provided to a member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair his/her ability to function in the community.
 - Designed to prevent a psychiatric inpatient admission, provide an alternative to inpatient admission, or shorten the length of inpatient stay.
 - Provided out of the member's home on a short-term basis in a community-based setting.
 - Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.
- Skilled nursing facility care in a licensed inpatient facility, including:
 - Room and board.
 - Physician and nursing care.
 - Medical social services.
 - Medical and biological supplies.
 - Respiratory therapy.
- Therapy and rehabilitation services, if the plan physician determines significant improvement is achievable within a two-month period, including:
 - Up to 30 visits of physical or occupational or speech therapy per year per injury, incident, or condition (physical therapy is limited to the restoration of an existing physical function; occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living; speech therapy is limited to treatment for speech impairments due to injury or illness).
 - Multi-disciplinary rehabilitation services (incorporating more than one therapy at a time) in a plan hospital, plan medical center, plan provider's medical office, or a skilled nursing facility (limited to a maximum of two consecutive months of treatment per injury, incident or condition).
 - Cardiac rehabilitation services following coronary surgery or a myocardial infarction for up to 12 weeks, or 36 sessions (whichever occurs first). The two-month improvement limit does not apply to cardiac rehabilitation.
- Transplants, if certain criteria are met (as outlined in the evidence of coverage), including reasonable medical and hospital expenses associated with stem cell rescues and transplants of organs, tissue, or bone marrow.
- Urgent care services anywhere in the world. Note that:
 - Your copay depends on the place of service.
 - If you are outside of the service area, a plan provider or plan facility must provide any follow-up care.
 - Medically necessary follow-up care related to emergency surgery (in consultation with your primary care physician) is covered when the plan authorizes, refers, or otherwise allows you access to a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery.

- Vision services, including:
 - Eye exams to determine the need for vision correction (copay may depend on whether exam is performed in an optometry department or ophthalmology department).
 - Discount on regular eyeglass lenses and frames when purchased at a Kaiser optical shop.
 - Discount on the initial purchase of contact lenses, when purchased at a Kaiser optical shop.
- Visiting member services when you are temporarily (not more than 90 days, except for a dependent child in college) a visiting member in a different Kaiser Foundation health plan or allied plan service area. The same medically necessary services that are covered under this plan and your cost are the same as when in the service area. Contact member services for details.
- X-ray, laboratory, and special procedures when prescribed as part of care covered under the plan, including:
 - Diagnostic imaging and interventional diagnostic tests.
 - Laboratory tests, including tests for specific genetic disorders for which counseling is available.
 - Special procedures, such as electrocardiograms and electroencephalograms.
 - Sleep lab and sleep studies.
 - Specialty imaging, such as CT, MRS, PET scans, and nuclear medicine studies.

For more information, including copays, etc., see the table at the beginning of this section, or contact the plan. Also see the definition of Kaiser terms later in this section. Finally, be sure to refer to the next section, What's Not Covered. For even more details, review the official plan documents.

What's Not Covered

Your group evidence of coverage provides a detailed list of exclusions, limitations, and potential benefit reductions under the plan (i.e., as the result of other types of coverage). Below is a summary of exclusions, which is not a complete list:

- Alternative medical services, such as naturopathy and massage therapy (unless otherwise covered under the plan).
- Alternative medicine services:
 - Requested by the member that are deemed not medically necessary by the primary care plan physician in consultation with the Kaiser Permanente Complementary Alternative Medicine Department; and
 - Requested when the member's medical condition does not satisfy health plan's clinical guidelines established for alternative care.
- Certain exams and services, such as physical examinations and other services required for:
 - Obtaining or maintaining employment or participation in employee programs; or
 - Insurance or licensing; or
 - On court order or required for parole or probation.
- Cosmetic surgery, services, supplies, ointments, etc. that are intended primarily to improve your appearance and that will not result in significant improvement in physical function (exceptions may apply for certain reconstructive surgery or cleft lip, cleft palate, or both).

- Dental care and dental x-rays, including:
 - Dental appliances, implants, orthodontia, etc.;
 - Dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment;
 - Any dental treatment, anesthesia, or facility charges involved in temporomandibular joint (TMJ) pain dysfunction syndrome; and
 - Services for teeth that have been knocked out or that have been so severely damaged that in the opinion of the plan provider, restoration is impossible.
- Directed blood donations.
- Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances, or devices not specifically listed as covered under the plan.
- Drugs, supplies, and supplements:
 - Drugs for which a prescription is not required by law.
 - Drugs, supplies, and supplements that can be self-administered or do not require administration or observation by medical personnel.
 - Drugs for the treatment of sexual dysfunction disorders.
 - Drugs for the treatment of infertility (certain administered drugs may be covered if necessary for in-vitro fertilization).
- Durable medical equipment that is not specifically listed as covered under the plan. These may include:
 - Comfort, convenience, or luxury equipment or features.
 - Exercise or hygiene equipment.
 - Non-medical items such as sauna baths or elevators.
 - Modifications to your home or car.
 - Devices for testing blood or other body substances (except if covered under diabetes supplies).
 - Electronic monitors of the heart or lungs, except infant apnea monitors.
- Emergency services:
 - Except as provided for continuing or follow-up treatment after emergency surgery, the plan does not cover continuing or follow-up treatment after emergency services unless authorized by the health plan.
 - The plan covers only the out-of-plan emergency services that are required before you could, without medically harmful results, have been moved to a facility the plan designates either inside or outside the service area.
- Experimental/investigational services, as determined by the health plan (exceptions may apply for certain clinical trials.)

- External prosthetic and orthotic devices:
 - More than one piece of equipment or device for the same part of the body (except for replacements, space devices, or alternate use devices).
 - Dental prostheses, devices, and appliances.
 - Hearing aids.
 - Corrective lenses and eyeglasses.
 - Repair or replacement due to misuse or loss.
 - Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace
 - Non-rigid appliances and supplies (for example, jobst stockings, elastic garments and stockings, and garter belts).
- Financial responsibility for services that an employer or government agency is required by law to provide.
- Habilitative services provided through federal, state, or local early intervention programs, including school programs.
- Hearing services (except for hearing aids for children, as listed under the section What's Covered), including:
 - Tests to determine an appropriate hearing aid.
 - Hearing aids or tests to determine their efficacy.
 - Replacement parts and batteries.
 - Replacement of lost or broken hearing aids.
 - Comfort, convenience, or luxury equipment or features.
- Home health care services, including:
 - Custodial care (see the section called Kaiser HMO Definitions).
 - Routine administration of oral medications, eye drops, and ointments.
 - General maintenance care of colostomy, ileostomy, and ureterostomy.
 - Medical supplies or dressings applied by a member or family caregiver.
 - Corrective appliances, artificial aids, and orthopedic devices.
 - Homemaker services.
 - Care that a plan provider determines may be provided in a plan facility.
 - Transportation and delivery service costs of equipment, medications, supplies, and supplements to the home.
- Hospice care: if you elect hospice care services through home or inpatient care, you are not entitled to any other benefits for the terminal illness, as outlined in the evidence of coverage.
- Infertility services:
 - Any charges associated with freezing, storage, and thawing of fertilized eggs, female members' eggs, and/or male members' sperm for future attempts.
 - Assisted reproductive procedures and any related testing or service that includes the use of donor sperm, eggs, or embryos.
 - Any charges associated with donor eggs, sperm, or embryos.
 - Infertility services, except for covered services for in vitro fertilization, when the member does not meet medical guidelines established by the American Society of Reproductive Medicine and the American Society for Reproductive Endocrinology.

- Infertility services, when the infertility is the result of an elective male or female surgical procedure.
- Assisted reproductive technologies and procedures other than those described above, including but not limited to: gamete intrafallopian transfers (GIFT) and zygote intrafallopian transfers (ZIFT), as well as related prescription drugs.
- Medical food for treatment of any conditions other than an inherited metabolic disease.
- Mental health and chemical dependency services for:
 - Members who, in the opinion of the plan provider, are seeking services and supplies for other than therapeutic purposes.
 - Evaluations that are primarily for legal or administrative purposes and are not medically necessary.
 - Psychological and neuropsychological testing for ability, aptitude, intelligence, or interest.
 - Services on court order or as a condition of parole or probation, unless determined by the plan provider to be necessary and appropriate.
- Oral surgery:
 - Oral surgery when the functional aspect is minimal and would not in itself warrant surgery.
 - Lab fees associated with cysts that are considered dental under the plan's standards.
 - Orthodontic services.
 - Dental appliances.
- Prescription drugs (covered under a separate benefit plan, administered by Express Scripts).
- Prohibited referrals, which means payment for any claim, bill, or other demand or request for payment for covered services determined to be supplied as the result of a referral prohibited by law.
- Prosthetic devices:
 - Internally implanted breast prosthetics for cosmetic purposes.
 - External prosthetics or orthotics not listed under the section What's Covered.
 - Repair or replacement of prosthetics due to loss or misuse.
- Routine foot care services that are not medically necessary (not including services when you are under active treatment for a metabolic or peripheral vascular disease).
- Services for members in the custody of law enforcement officers, such as non-plan provider services provided or arranged by criminal justice institutions for members in the custody of law enforcement officers, unless the services are covered as out-of-plan emergency services.
- Services you receive outside of the health plan's service area for conditions that, before leaving the service area, you should have known might require services while you are away (such as dialysis for end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless the plan determines that you were temporarily outside of the service area because of extreme personal emergency).
- Skilled nursing services such as custodial and domiciliary care.
- Surrogacy arrangements. (You must pay the health plan charges for services you receive related to conception, pregnancy, or delivery in connection with a surrogacy arrangement. See your group evidence of coverage for details.)
- Therapy and rehabilitation services for any therapy that the plan physician determines cannot achieve measurable improvement in function within a two-month period (except for cardiac rehabilitation).
- Transplant services related to non-human or artificial organs and their implantation.
- Transportation by car, taxi, bus, gurney van, wheelchair, van, and any other type of transportation (other than ambulance), even if it is the only way to travel to a plan provider.

- Travel and lodging expenses, except in certain situations (for example, if a plan physician refers you to a non-plan provider outside of Kaiser's service area, the plan may pay for certain authorized expenses).
- Urgent care services within Kaiser's service area that were not provided by a plan provider or plan facility.
- Vision services, such as:
 - Eye surgery solely for correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy and similar procedures).
 - Sunglasses without corrective lenses unless medically necessary.
 - Eye exercises.
 - Cosmetic contact lenses.
 - All services related to contact lenses, including exams, fittings, and follow-up visits (except services listed under the section What's Covered).
 - Replacement of lost or broken lenses or frames.
 - Orthoptic (eye training) therapy.
- Workers' compensation or employer's liability: financial responsibility for services for any illness, injury, or condition, to the extent payment or any other benefits (including any amount received as a settlement), is provided under any workers' compensation or employer's liability law.
- 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 the health plan.
- Services that are not specifically shown in Kaiser's group evidence of coverage as a covered service or that do not meet all other conditions and criteria for coverage as determined by the health plan.
- The above exclusions also apply if you are a visiting member in a different Kaiser Foundation health plan or allied plan service area.

Claims Payment and Appeals

No Claims for Plan Services

When you use a plan provider, hospital, or facility for care, you generally do not have to file a claim with the health plan. You simply pay your copay amount when you receive the service.

Filing Claims for Non-Plan Services

If you receive emergency care from a non-plan provider, you will need to keep all of your receipts and verify whether the provider has submitted the claims. All claims must be filed within six months of the date of service, or as soon as reasonably possible (and except in the absence of legal capacity, no later than one year from the time proof was otherwise required). Send claims to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
P.O. Box 6233
Rockville, MD 20849-6233

Complaints and Grievances

Member services representatives are available to assist you with submitting a request for payment and/or reimbursement for emergency services and urgent care services outside of the service area or to initiate an appeal or a grievance for an unresolved issue. We encourage you to first discuss any issues with your primary care plan provider or other health care professionals treating you. If you are not satisfied with your primary care plan provider, you can request a different plan provider by calling member services. Refer to your evidence of coverage for details on the following:

- Health care services review process; and
- Grievance and appeal process.

Other Information

Converting to an Individual Policy

You may be eligible to convert to a non-group plan, if you:

- Are no longer eligible for coverage under the plan; or
- Enroll in COBRA or state continuation of coverage and then lose eligibility for that coverage.

You may not convert to the non-group plan if:

- You continue to be eligible for coverage through the City Schools.
- You live in another Kaiser Foundation health plan or allied plan service area.
- Your membership was terminated for “cause,” such as failure to pay a premium.

If eligible, you must apply to convert your membership with 31 days after your group coverage ends, or the date the plan notifies you of your conversion rights (which is later). For more details, contact member services.

Overpayment Recovery

The health plan may recover any overpayment made for services from anyone who receives an overpayment, or from any one person or organization obligated to pay for the services. If the health plan has made a payment to a health care provider, the plan may only retroactively deny reimbursement to the provider during the six-month period after the date the plan paid the claim submitted by the provider.

Assignment of Benefits

You may not assign any of the rights, interests, claims for money due, benefits, or obligations under the plan, without prior written consent from the health plan.

Other Administrative Information

For information on COBRA coverage and other plan benefits, please see the Important Information section of this guide.

Kaiser HMO Definitions

Allowable Charges (AC) – means either:

- For services provided by health plan or medical group, the amount in the health plan’s schedule of medical group and health plan charges for services provided to members;
- For items obtained at a plan pharmacy, the “member standard value” which means the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
- For all other services,
 - The amount the provider has contracted to accept;
 - The amount the provider has negotiated with the health plan;
 - The amount stated in the fee schedule that providers have agreed to accept as payment for those services; or
 - The amount that the health plan pays for those services.
- For non-plan providers, the allowable charge shall not be less than the amount the health plan must pay pursuant to §19-710.1 of the health general article of the annotated code of Maryland.

Body Mass Index – assesses a person’s degree of obesity by dividing weight in kilograms by height in meters squared.

Coinsurance – the percentage of allowable charges that you must pay when you receive a covered service.

Copayment (or copay) – a specific dollar amount that you must pay when you receive a covered service.

Cost Share – the amount of the allowable charge that you must pay for covered services through copayments and coinsurance.

Covered Service – a medically necessary service or supply provided according to the terms of Kaiser Permanente’s evidence of coverage.

Custodial Care – assistance with activities of daily living, such as walking, bathing, feeding, etc., or care that can be performed safely and effectively by people, who in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

Dependent – a member whose relationship to a subscriber is the basis for membership eligibility and who meets the eligibility requirements as a dependent.

Deductible – the dollar amount you must pay before Kaiser will pay for all or part of remaining covered services. The deductible is met when you receive covered services based on the allowed benefit that are subject to the deductible and you pay for those services yourself.

Durable Medical Equipment – equipment that is intended for repeated use; is primarily and customarily used to serve a medical purpose; is generally not useful in the absence of illness or injury; and meets health plan criteria for medical necessity.

Effective Date – the date your coverage becomes effective. Covered services provided on or after your effective date are eligible for coverage.

Emergency Services – health care services that are provided in a hospital emergency facility (or independent freestanding emergency department) after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- Placing the patient’s health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- In the case of a pregnant woman, serious jeopardy to the health of the mother and/or fetus.

Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as Kaiser determines as well as items and services for which benefits are provided or covered under the plan or coverage and that are furnished by a nonparticipating provider or nonparticipating emergency facility, regardless of the department of the hospital in which such items or services are furnished, after the participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the emergency visit.

Evidence of Coverage – the agreement between the City Schools and Kaiser Permanente that describes the details of the plan, including covered services, plan exclusions, and plan limits.

Family Unit – a subscriber and all of his or her enrolled dependents.

Fee Schedule – a listing of procedure-specific fees developed by health plan and for which the plan provider agrees to accept as payment in full for covered services rendered.

FDA – the federal Food and Drug Administration.

Habilitative Services – medically necessary services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, including services that enhance functional ability without effecting a cure (for example, speech, occupational, or physical therapy for children under age 19 with a congenital or genetic birth defect – including but not limited to autism or an autism spectrum disorder, and cerebral palsy).

Health Plan – Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. The evidence of coverage sometimes refers to health plan as “we” or “us.”

Hearing Aid – a non-disposable device designed to optimize audibility and listening skills in the environment commonly experienced by children.

Home Health Services – medically necessary health services that can be safely and effectively provided in your home by health care personnel and are directed by a plan provider. They include visits by registered nurses, practical nurses, or home health aides who work under the supervision or direction of a registered nurse or medical doctor.

Hospice Care – a coordinated, inter-disciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health care services through home or inpatient care during the illness and bereavement to individuals who have no reasonable prospect of cure as estimated by a physician and the immediate family or family caregiver. “Family caregiver” is a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill member. “Respite care” is temporary care provided to the terminally ill member to relieve the family caregiver from the daily care of the member.

Kaiser Permanente – Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Mid-Atlantic Permanente Medical Group, and Kaiser Foundation Hospital.

Medical Group – Mid-Atlantic Permanente Medical Group.

Medicare – a federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Medically Necessary or Medical Necessity – a service is medically necessary only if the plan’s physician determines that it is medically appropriate for you and, based on medical guidelines, there is a reasonable possibility that its omission would adversely affect your health.

Member – an individual who meets the eligibility requirements, is enrolled either as a subscriber (employee) or dependent, and for whom premiums have been received by Kaiser Permanente. For simplicity, instead of “member,” this guide refers to “you” or “your.”

Morbid obesity – a person has a body mass index greater than 40 kilograms per meter squared or at least 35 kilograms per meter squared, along with hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

Open Enrollment – a single period of time each year during which you can change coverage or enroll in coverage. For City Schools’ employees, open enrollment is held during the fall of each year, for an effective date of January 1 of the following year.

Orthotic Device – an appliance or apparatus used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body.

Plan – Kaiser Permanente.

Plan Facility – a plan medical center, a plan provider’s medical office, a plan provider’s facility, or a plan hospital.

Plan Hospital – any hospital in our service area where you receive hospital care pursuant to our arrangements made by a plan physician.

Plan Medical Center – a building within our service area that is owned and operated by us in which medical group practices medicine and provides primary care, specialty care, and ancillary care services to members.

Plan Physician – any licensed physician who is an employee of medical group, or any licensed physician who contracts with us to provide services and supplies to members.

Plan Provider – a plan hospital, plan physician, or other health care provider that contracts with us to provide services to members.

Premium – the dollar amount you pay for coverage under the plan.

Service Area – the areas of the District of Columbia; the following Virginia counties – Arlington, Fairfax, Prince William, Loudoun; the following Virginia cities – Falls Church, Fairfax, Alexandria, Manassas, and Manassas Part; the following Maryland areas: the City of Baltimore; the following Maryland counties: Baltimore, Carroll, Harford, Anne Arundel, Howard, Montgomery, and Prince George’s, and specific zip codes within Calvert, Charles, and Frederick counties. A listing of these zip codes may be obtained from any health plan office.

Prosthetic Device – an artificial substitute for a missing body part used for functional reasons.

Services – health care services or items.

Skilled Nursing Facility – a facility that provides inpatient skilled nursing care, rehabilitation services, or other related health care services and is certified by Medicare. The facility’s primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term “skilled nursing facility” does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Specialist – a physician who is certified or trained in a specified field of medicine (for example, cardiology).

Spouse – your legal husband or wife.

Subscriber – a member who is eligible for membership on his or her own behalf and not by virtue of dependent status (unless coverage is provided under a continuation of coverage provision) and who meets the eligibility requirements as a subscriber.

Urgent Care Services – services required as the result of a sudden illness or injury, which requires prompt attention, but are not of an emergent nature.

For More Information

For more information about the Kaiser HMO plan, visit Kaiser’s website at www.kp.org, or call Kaiser at 301-468-6000 or 1-800-777-7902 (toll-free).

Other Medical Benefits Information

Major Medical Program

Members of the PSASA union will automatically be enrolled in the stand-alone Major Medical Program. You will receive a membership card after you complete one month of service. This benefit entitles you to request reimbursement for the expenses outlined below. Members of BTU, PSRP, CUB, AFSCME, Local 44, and non-represented employees receive major medical benefits in conjunction with the health plan in which they are enrolled.

Eligible Major Medical Expenses

- Physician services – medical care or treatment (outpatient or office);
- Private duty nursing – R.N. or L.P.N., only with a letter from the physician ordering the service and pre-certification from the administrator;
- Physical and rehabilitation therapy – 100 visits per year (physical, speech, and occupational therapies combined);
- Rental or purchase of durable medical equipment (rental cost not to exceed purchase price);
- Medical supplies such as diabetic supplies, colostomy supplies, and surgical stockings;
- Whole blood (if not replaced);
- Oxygen;
- Dental;
- Accidental injury to natural teeth. All work must be done within 90 days of the accident;
- Treatment of temporomandibular joint syndrome (TMJ) – limited services; and
- Ambulance used locally to or from a hospital when related to inpatient care or following accidental bodily injury (local, ground only).

All bills must be submitted within 15 months from the date of service and are subject to medical review and contract limitations. The major medical program only covers the services listed above. It does not cover all of your medical expenses. Review the benefit comparison chart for a list of medical services provided by the health plan to assist you in selecting a health plan that will meet the needs of you and your family.

Baltimore City Public Schools Major Medical Insurance Summary	
Administrator	CareFirst BlueCross BlueShield 10455 Mill Run Circle Owings Mills, MD 21117 410-581-3508
Policy Year	January 1 – December 31
Deductible Plan Year	\$150 per person per policy year Three-person family deductible: \$400 per family
Benefit Percentage	All allowed benefits (including mental health): • 80% of the first \$2,000 of eligible medical expenses incurred in benefit period • 100% of all other eligible medical expenses incurred within the same benefit period in excess of \$2,000

Health Incentive Reimbursement Program

Eligibility

If you are a member of PSASA, CUB, or an employee not unaffiliated with a union, when you complete six months of service, you are eligible for certain reimbursement benefits, as follows. You may be reimbursed up to \$150* annually or bi-annually when you experience costs related to:

- Your physical examination; or
- Your physical fitness programs (dance classes and weight reduction programs are not eligible).

You will not receive reimbursement for both services.

*Effective 1/1/03

Under Age 40

You may be reimbursed up to \$150* every two years if you are age 39 and under. A year begins with the date of the last physical examination or fitness program registration/enrollment. If you are under age 40, you may request a health incentive reimbursement of \$50 during the alternative year that you are not eligible to receive the \$150* incentive.

*Effective 1/1/03

Over Age 40

You may be reimbursed up to \$150* a year if you are age 40 or over. A year begins with the date of the last physical examination or fitness program registration/enrollment. Dependents of employees are not eligible to participate in this program.

*Effective 1/1/03

Receiving Reimbursements for a Physical Examination

Send your written request for reimbursement to the Department of Employee Services within 60 days of the date of your physical examination, along with the following:

- An original receipt of your physical examination; and
- An explanation of benefits (EOB) from your health plan, or proof that the claims for the examination were rejected by your health plan.

You may not receive reimbursement from City Schools for expenses that are paid by a health plan.

Receiving Reimbursements for Physical Fitness Programs

Your request for reimbursement and supporting documentation should be submitted to the Department of Employee Services, 200 E. North Ave., Room 110, Baltimore, MD 21202. Upon receipt, we will verify that all requirements are met before reimbursement is issued.

End Stage Renal Disease (ESRD)

Individuals who have permanent kidney failure, also known as end stage renal disease (ESRD), can receive services through Medicare. If you or your eligible dependent(s) are certified by Medicare as eligible for ESRD coverage, you should contact Medicare to obtain enrollment instructions. Your City Schools health plan will be your primary plan for the first 30 months of ESRD (effective March 1, 1996). At the end of the 30-month period, Medicare becomes the primary payer and the City Schools health plan in which you are enrolled (CareFirst PPN, CareFirst BlueChoice POS, or Kaiser Permanente HMO health plan) will be secondary.

It is extremely important that you contact your local Social Security office at 1-800-638-6833 and request a Medicare benefits handbook that provides information on coverage for kidney dialysis and kidney transplant services. Additionally, you must contact the Office of Benefits Management at 410-396-8885 to update your health plan records.

Experimental Medical Procedures

Experimental procedures are not covered by any City Schools health plan. You must contact your health plan in writing and request written approval from them before receiving any medical care which may be considered experimental. Contact your health plan with any questions regarding experimental medical procedures.

If You Travel Out of the Country

If you or your eligible dependents are enrolled in a City Schools health plan and you plan to travel outside the United States, be sure to contact your health plan before leaving. They will give you information about how to access your health plan benefits if you or eligible dependents should require medical attention. Remember, there may be benefit restrictions and/or limitations.

Your Prescription Drug Benefits

Baltimore City Public Schools prescription drug coverage is offered through Express Scripts. This coverage is considered to have grandfathered status related to the Affordable Care Act (ACA), which means that it may not include some provisions provided under ACA. Grandfathered status does not apply to Medicare, Medicaid, or retiree-only plans. If this coverage loses grandfathered status, provisions of the ACA would apply when a new plan or policy year begins. For this plan to preserve grandfathered status, only minimal plan changes may be made without losing grandfathered status.

If you want to have prescription drug coverage, you must enroll in the prescription drug plan through Express Scripts. Your prescription drug coverage election is separate from any enrollment you may make in a Baltimore City Public Schools health plan and you are not required to enroll in health plan coverage to enroll in prescription drug coverage. You pay a copay each time you fill a prescription. How much you pay for your prescriptions depends on the type of drug you need, and whether you fill it at your local pharmacy or take advantage of home delivery through the Express Scripts Pharmacy. Through this program, you can receive a 90-day supply of maintenance medications from your local pharmacy. You may use home delivery through the Express Scripts Pharmacy for medications that will be taken on a regular or long-term basis. Some examples of eligible medications include those used for high blood pressure, high cholesterol levels, arthritis, heart or thyroid conditions, and diabetes. Whether or not you use a generic drug, brand name drug, or non preferred drug will also influence how much you pay.

	Participating Retail Pharmacy (up to 90-day supply)	Home Delivery Pharmacy (90-day supply)
Generic Drugs	\$10 copay	\$10 copay
Brand Name Drugs	\$15 copay	\$15 copay
Non Preferred Drugs	\$30 copay	\$30 copay

Generic substitutes mandatory unless brand drug is medically necessary.

Please note: Viagra is limited to 6 tablets per 30 days.

Generic Drugs

Generic prescription drugs have the same active ingredients in the same dosage form and strength as their brand name counterparts.

The U.S. Food and Drug Administration (FDA) approves both brand name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand name drugs. These requirements ensure that generic drugs are as safe and effective as brand name drugs.

Generics Preferred

Generics Preferred is a program used which encourages the use of generic drugs. There are some brand name drugs, such as Amaryl and Zithromax, for which generic equivalents are available. If you fill a prescription for a brand name medicine for which there is a generic equivalent, then the amount you will pay for the brand name drug will increase from the brand name drug copay only to the difference in price between the generic and the brand name prescription **plus** the brand name copay.

If you choose to use brand name drugs instead of generics, you must pay this cost differential yourself, as show below.

Example	If You Choose Generic	If You Choose Brand Name
Cost of brand name: \$50 Cost of generic equivalent: \$30 Cost difference: \$20	You pay \$10 retail generic copay	You pay \$35 (\$15 retail brand name copay plus \$20 cost difference)

Brand Name drugs

Any prescription drug that is mainly identified and marketed under a protected brand name or trade name by an individual drug manufacturer.

Formulary List

Based on the City Schools prescription drug copay structure, you may save money on brand name drugs if they are on the Express Scripts-approved formulary list. The drugs on the formulary list are selected based on, but not limited to, the drug's effectiveness, safety, therapeutic role in the management of disease, and the cost. The list contains common drug classes and is updated on a periodic basis. You may request a copy of the formulary list from Express Scripts by calling 1-877-206-7430, or by visiting their web site (<http://www.express-scripts.com>).

Prior Authorization

Some prescription drugs on your plan will require prior authorization. This means that Express Scripts will make sure these prescriptions meet the Baltimore City Public School System's plan conditions for coverage. Prior authorization encourages appropriate drug therapy for certain designated conditions.

To determine if your medicine requires a prior authorization, log in to www.express-scripts.com and use the Price a Medication feature. After you look up a medicine's name, click View Coverage Notes, or you can call Member Services at 877-206-7430. As you receive new prescriptions, remember to check the prior authorization list to see if the medicines will be covered, as the list is subject to change.

Quantity per Dispensing Limits/Allowances

To promote member safety and appropriate and cost-effective use of medicines, your prescription plan includes a "drug quantity management" program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you receive at one time.

Quantity per dispensing limits/allowances are based on the following:

- The manufacturer's recommended dosage and duration of therapy
- Common usage for episodic or intermittent treatment
- FDA-approved recommendations and/or clinical studies
- As determined by your plan

Specialty Medications

Accredo, the full-service Express Scripts specialty pharmacy, provides personalized care to patients with chronic, complex health conditions. Accredo offers several comprehensive disease-specific patient-care management programs:

- **Patient counseling** – convenient access to highly trained specialty experts, including pharmacists, nurses and patient care coordinators who provide the support you need to manage your condition
- **Patient education** – clinicians and disease-specific educational materials available 24/7
- **Convenient medicine delivery** – coordinated delivery to your home, doctor’s office or any other approved location
- **Refill reminders** – ongoing refill reminders from a patient care coordinator
- **Language assistance** – translation services are available for non-English speaking patients

For additional information about the services available to you through Accredo, please call (800) 922-8279.

Through programs specific to your condition, you can receive a complete range of services and specialty medicines – many of which can be very costly and are often unavailable through retail pharmacies. The conditions include but are not limited to:

- Cancer
- Hemophilia
- Hepatitis
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Respiratory syncytial virus
- Rheumatoid arthritis

Filling Your Prescriptions

You have two ways to fill your prescriptions: at a participating retail pharmacy or through home delivery from the Express Scripts Pharmacy.

Short-Term Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when filling a prescription for a short-term prescription that you need immediately (for example, antibiotics for strep throat or painkillers for an injury). Simply present your Express Scripts ID card to your pharmacist with your written prescription and pay the required copayment.

Please be aware that prescriptions filled at a non-participating retail pharmacy are not covered. Please note that prescriptions filled outside the United States while you are traveling will be covered only if they have U.S. equivalents.

You can locate the nearest participating retail pharmacy anytime online at [express-scripts.com](https://www.express-scripts.com) or by calling 877-206-7430.

Long-Term Prescriptions Through the Express Scripts Pharmacy

Home delivery is your best option for prescription drugs you take on a regular basis for conditions such as asthma, heartburn, high blood pressure, allergies and high cholesterol.

Your prescriptions are filled and double-checked by Express Scripts’ licensed pharmacists and conveniently sent to you in a plain weather-resistant pouch for privacy and protection.

A pharmacist is available 24 hours a day to answer your questions about your medicine.

Convenient for you

You get up to a 90-day supply of your medicines – which means fewer refills and fewer visits to your pharmacy. Once you begin using home delivery, you can order refills online, by phone or by mail. You can obtain a home delivery order form anytime online at www.express-scripts.com or by calling 877-206-7430.

Using Home Delivery

To begin using home delivery for your prescriptions, just follow these three simple steps:

- Ask your doctor to write a prescription for up to a 90-day supply of your medicine plus refills for up to one year, if appropriate.
- Complete a home delivery order form.
- Insert your prescription, payment and completed order form into the mail order envelope and mail it to Express Scripts.

You will receive your prescription drug within 10 to 14 business days from the day you mailed the prescription to us with no charge for standard U.S. Postal Service delivery. You can request overnight delivery for an additional charge.

The Best Choice for You

To help you and your doctor determine the most appropriate cost-effective drugs for you, be sure to ask your doctor if a generic is available. This simple question may save you money on your copayment.

What's Not Covered

The exclusions listed below are items that are not covered expenses under the prescription drug plan. This list is subject to change.

- Homeopathic drugs
- Serums, toxoids, and vaccines
- Weight management agents
- Contraceptive implants
- IUD
- Contraceptive devices
- Biological sera, blood, or blood plasma
- Photoaged skin products
- Legend hair growth agents
- Injectable cosmetics
- Depigmentation agents
- Legend multi-vitamins
- Legend supplemental vitamins
- Yohimbine
- Durable medical equipment
- Therapeutic devices
- Drugs obtained without a prescription order, except insulin and syringes
- All diabetic supplies (however, insulin syringes are covered)
- Excluded products on the National Preferred Formulary

How Claims are Paid

Generally, you do not need to submit claims under the prescription drug plan. You simply pay your copay when you fill your prescription. However, if you do need to submit a claim (for example, because the pharmacy's computer system is not working), call Express Scripts for a claim form and send your claim to:

Express Scripts
P.O. Box 66583
St. Louis, MO 63166

Express Scripts Definitions

“Average Wholesale Price” or “AWP” – the average wholesale price of a prescription drug as identified by drug pricing services such as First Data Bank or other source recognized in the retail prescription drug industry selected by ESI for all clients.

Brand drug – a prescription drug product that is not a generic drug.

Copayment, or copay – your portion of the charge for each covered prescription drug.

Covered Drug(s) – prescription drugs, supplies, specialty products (if applicable), and other items that are covered under the plan.

Formulary – the list of FDA-approved prescription drugs and supplies developed by ESI's Pharmacy and Therapeutics Committee.

Generic drug – a prescription drug, whether identified by its chemical, proprietary, or nonproprietary name, that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA.

HIPAA – the Health Insurance Portability and Accountability Act of 1996, as amended.

Mail Service pharmacy – a duly licensed pharmacy operated by ESI or its subsidiaries, where prescriptions are filled and delivered via mail delivery service. Also called “Home Delivery.”

Participating pharmacy – any licensed retail pharmacy with which ESI has an agreement to provide covered drugs to plan members.

Specialty products – those injectable and non-injectable drugs that typically have one or more of several key characteristics, including:

- frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes;
- intensive patient training and compliance assistance to facilitate therapeutic goals;
- limited or exclusive product availability and distribution;
- specialized product handling and/or administration requirements and/or cost in excess of \$500 for a 30-day supply.

Usual and Customary Price or U&C – the retail price charged by a participating pharmacy for the particular drug in a cash transaction on the date the drug is dispensed as reported to ESI by the participating pharmacy.

For More Information

You can contact the prescription drug plan at any time online at www.express-scripts.com or by calling customer service at 1-877-206-7430.

Your Dental Benefits

As a benefit-eligible employee, you may enroll in dental benefits to help cover the expenses of many different dental services and procedures. You may choose from two different dental plans:

- CareFirst DHMO Plan (Basic Dental)
- CareFirst Preferred Dental PPO (Dental Buy-Up)

Waiving Dental Coverage

You may elect to waive dental coverage if you wish. You may do so when you are first hired or during any open enrollment period. During these enrollment opportunities, you will have to complete a Benefit Selection Form (during open enrollment season, the procedure is different – only online enrollment is allowed).

Basic Dental: CareFirst DHMO (Dental Health Maintenance Organization) Plan

This plan is administered by the Dental Network, an independent licensee of the BlueCross and BlueShield Organization. City Schools pays the full premium for your enrollment in this plan. This plan is also referred to as a Dental Health Maintenance Organization, or DHMO plan. This is only a summary. If there are any discrepancies between this description and the official plan documents, the official plan documents will determine benefits.

Participating General Dentists

You must designate a participating general dentist as your provider before you can receive benefits under this plan. He or she will provide your dental care or refer you to an in-network specialist as needed. You and your covered dependents may each choose a different participating general dentist. If you do not choose a participating dentist, the plan will assign one for you and each covered family member based on your zip code.

If you are dissatisfied with your participating general dentist, you may choose a different one at any time, and the change will be effective the first day of the following month.

Dental Specialists

When you need specialty dental care, your participating general dentist will refer you to a participating (in-network) dental specialist. The plan will not pay benefits for specialty care without this referral.

Emergency Care

If you have a dental emergency when you are more than 50 miles from home, you should visit any dentist to receive immediate care. A dental emergency involves acute pain and treatment needed due to pain, swelling, and bleeding. The plan will cover the cost of diagnostic and therapeutic procedures up to \$50 per emergency.

What's Covered

The DHMO plan pays benefits for most types of dental care services. For many basic services – such as oral exams, fluoride treatments, and X-rays – you pay nothing when you use in-network dentists. For more major dental services – including restorative care, endodontics, and orthodontia for children and adults, to name a few – you pay a portion of the cost depending upon the type of service you need. The following chart lists your share of costs for some dental services under the DHMO plan when you receive care from your participating dentist. This is only a partial list of covered services. A complete list of covered services is available in the official plan documents. For a full copy of the schedule of benefits, visit CareFirst's website at www.carefirst.com.

Dental Services	When Provided by In-Network Provider You Pay
Periodic Oral Evaluations (once per 6 months)	\$0
Bitewings (2 films)	\$0
Panoramic Film	\$0
Prophylaxis (cleaning) for Adult (once per 6 months)	\$0
Prophylaxis (cleaning) for Child (once per 6 months)	\$0
Amalgam (1 surface, permanent)	\$0
Amalgam (3 surface, permanent)	\$0
Resin-Based Composite (1 surface, anterior)	\$0
Resin-Based Composite (3 surface, anterior)	\$0
Crown (porcelain/high noble metal)	\$245
Crown (porcelain/noble metal)	\$235
Molar Root Canal	\$185 (general dentist) \$490 (specialist)
Osseous Surgery	\$196 (general dentist) \$495 (specialist)
Periodontal Scaling and Root Planing (quad)	\$40 (general dentist) \$86 (specialist)
Complete Denture (upper)	\$249
Extraction (erupted tooth or exposed root)	\$40 (general dentist) \$73 (specialist)
Surgical Extraction (erupted tooth)	\$40 (general dentist) \$80 (specialist)
Removal of Impacted Tooth (completely bony)	\$85 (general dentist) \$155 (specialist)
Comprehensive Orthodontic Treatment (adolescent)	\$1,850
Palliative Treatment	\$15

Note: this is not a complete list. For a complete list, refer to your official plan documents.

What's Not Covered

The plan will not pay benefits for:

- Services for injuries and conditions covered under Workers' Compensation or employers' liability laws.
- Services provided without cost to you by any municipality, county, or other political subdivision (with the exception of Medicaid).
- Services which, in the opinion of the participating dentist, are not necessary for your health.
- Any claim or bill resulting from a prohibited referral.
- Cosmetic, elective, or aesthetic dentistry, which, in the opinion of the participating dentist, are not necessary for your health.
- Oral surgery requiring the setting of fractures or dislocations.
- Services with respect to malignancies, cysts or neoplasms, or hereditary, congenital, or developmental malformations.
- Dispensing of drugs, except those used as a local anesthetic.
- Hospitalization for any dental procedure.
- Loss or theft of bridgework or dentures previously supplied under the plan.
- Replacement of a bridge, crown, or denture within five years after the date it was originally installed.
- Any implantation.
- General anesthesia.
- Services that cannot be performed because of your general health.
- Teeth cleaning more often than every six months.
- Services obtained outside the dental office in which you are enrolled and which are not pre-authorized by the plan (does not apply to out-of-area emergency dental services).
- Services which cannot be performed in the dental office of your participating general dentist or approved specialist due to special needs or health related condition.

Other Plan Limitations

- Unlisted procedures will be provided at the dentist's charge.
- Services provided by a pedodontist (pediatric dentist) are considered specialty care and must be approved by the covered person's general participating dentist.
- All services will be provided by a general participating dentist or approved specialist, if the general participating dentist believes the service or procedure must be provided by a specialist (with the exception of out-of-area emergencies).
- All prices are exclusive of gold.

Claims Payment and Appeals

You do not have to submit any claim forms under the DHMO plan. When you need care, visit your participating general dentist and pay your copay – that’s all! However, in the case of a dental emergency that occurs more than 50 miles from home, you will need to submit a claim form. If your claim is determined to be a true dental emergency, the plan will reimburse you for up to \$50 per emergency, minus any applicable copay.

If the plan denies coverage, in whole or in part, for any services, you will be notified within 30 days after the claim for benefits is submitted unless there are special circumstances that require an extension of time for processing the claim. If you wish to appeal any denied claim, you can do so in writing within 180 days of the claim denial. You may submit written comments, documents, records, and any other information relating to the claim.

For More Information

You can contact the dental plan at www.carefirst.com any time or by calling 1-866-891-2802, Monday through Friday, 8:30 a.m. to 5 p.m.

Dental Buy-Up: CareFirst Preferred Dental PPO

The CareFirst BlueCross BlueShield Preferred Dental Plan, also called the Dental PPO plan, allows you more freedom in accessing your dental care services than the DHMO plan. You pay a premium if you enroll in this coverage. This is only a summary. If there are any discrepancies between this description and the official plan documents, the official plan documents will determine benefits.

In-Network Providers

Under this plan, you may see any dentist you wish. You may see a dentist in the CareFirst Preferred Dental Network, or a dentist who does not participate in the network (called a non-preferred dentist). There are more than 2,300 dentists in Maryland who participate in CareFirst's Preferred Dental Network; more than 500 of them practice in Baltimore City.

Keep in mind, your out-of-pocket costs will be lower when you use a provider in CareFirst's network, and higher when you choose a non-preferred dentist for your dental care. And, there are no claim forms to file when you receive care in-network. In addition, preferred dentists have agreed to accept CareFirst's allowed benefit as payment in full for covered services. Once you satisfy your deductible and coinsurance, you will not have additional expenses with an in-network provider.

Out-of-Network Providers

If you choose to see an out-of-network dentist, you may need to pay the dentist at the time you receive care, and submit a claim form for reimbursement. The plan will reimburse you for covered services based on an out-of-network plan allowance schedule.

Please be aware that if an out-of-network dentist does not ask you to pay the whole bill when you receive care, you might be billed later for any difference between his or her actual charge and CareFirst's allowed benefit.

Specialists

If you are diagnosed with a condition or disease that requires you to see a specialist, you may request a referral to a non-preferred dentist as long as:

- CareFirst does not contract with a preferred specialist with the professional training and expertise to treat the condition or disease; or
- CareFirst cannot provide reasonable access to a preferred specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

In this case, your costs will be calculated as if you were seeing a preferred dentist.

Deductible

In-network and out-of-network deductibles of \$50 per year per individual and \$150 per year per family apply to all covered class II (basic) and class III (major) dental services. The deductible does not apply to class I (preventive and diagnostic) or class IV (orthodontia) dental services.

The in-network and out-of-network deductible is a combined amount. For example, if you pay \$20 for in-network services and \$30 for out-of-network services, you will have met your \$50 individual deductible for the

year. The deductible is calculated based on the allowed benefit of covered services. Amounts over the allowed benefit do not contribute toward your deductible.

For a family, all family members' charges combine to meet the family deductible. No one family member may contribute more than the individual deductible amount (\$50) to the family deductible amount. In addition, there is no carry-over deductible provision.

Annual Maximum for Class I, II, and III Dental Services (Preventive, Basic, and Major Services)

There is a combined in- and out-of-network annual maximum benefit per person for all preventive, basic, and major covered dental services of \$1,500. This means that you will reach your annual maximum once the plan has paid \$1,500 in benefits in a plan year, whether you received services in-network or out-of-network. Once you reach your annual maximum, CareFirst will not pay any additional preventive, basic, or major dental benefits for you for the remainder of the plan year.

Lifetime Maximum for Class IV Dental Services (Orthodontia)

There is a separate combined in- and out-of-network lifetime maximum for orthodontia services of \$1,500 per person. In other words, you will reach your lifetime maximum for orthodontia services once the plan has paid a total of \$1,500 in orthodontic benefits, whether the services you received were in-network or out-of-network.

What's Covered

The CareFirst Dental PPO covers preventive and diagnostic, basic, and major dental care services, in addition to orthodontia. The chart below summarizes the services covered under this plan. Not every dental service is shown. Also, keep in mind that other limits and exclusions may apply. If there are any discrepancies between this description and the official plan documents, the official plan documents will determine benefits.

Benefits	In-Network You Pay	Out-of-Network You Pay
Class I: Preventive and Diagnostic Services	\$0	Difference between CareFirst's payment and the dentist's charge**
Class II: Basic Services	20% of allowed benefit after deductible*	20% of allowed benefit after deductible**
Class III: Major Services	40% of allowed benefit after deductible	40% of allowed benefit after deductible
Class IV: Orthodontia Services	50% of allowed benefit after deductible*	50% of allowed benefit after deductible**
Annual Deductible (applies to Class II and III)	\$50/individual \$150/family	
Maximum	\$1,500 Annual Maximum \$1,500 Orthodontia Lifetime Maximum	

* For in-network providers, plan payment is based on dental plan's negotiated fee schedule. After the deductible is met, preferred dentists accept 100% of the allowed benefit as payment in full for covered dental services.

** If you use an out-of-network provider, you will need to pay the provider and will be reimbursed by the plan using an out-of-network plan allowance schedule. Your out-of-pocket costs will most likely be higher. Non-participating dentists may bill you for the difference (if any) between the allowed benefit and the non-participating dentist's actual charge for services.

Following is a list of what's covered under the different classes of dental services in the CareFirst Dental PPO plan.

Class I: Preventive and Diagnostic Services

- Twice per plan year:
 - Oral exam
 - Routine cleaning
 - Topical fluoride until the end of the year a member reaches age 19
 - Pulp vitality tests (additional tests may be allowed for accidental injury and trauma or other emergency)
 - Bitewing x-rays not taken at the same time as those below
- Once every 36 months:
 - One set of full mouth x-rays or one panograph x-ray and one additional set of bitewing x-rays
 - One cephalometric x-ray
 - Sealants on permanent molars, once per tooth per 36 months, until the end of the year a member reaches age 19
- Once every 60 months:
 - Space maintainers for prematurely lost cuspid to posterior deciduous teeth
- As needed:
 - Palliative treatments
 - Emergency oral exam
 - Periapical and occlusal x-rays
 - Professional consultation with a dentist (one consultation per dentist per condition)

Class II: Basic Services

- Direct placement fillings, including direct pulp caps, limited to:
 - Silver amalgam, silicate, plastic, composite, or equivalent material approved by CareFirst
 - One filling per surface per 12 months
- Simple extractions without general anesthesia
- Oral surgical services as required:
 - Surgical extractions, including impactions
 - Oral surgery, including treatment for cysts, tumors, and abscesses
 - Biopsies of oral tissue if a biopsy report is submitted
 - General anesthesia and/or IV sedation, if required for oral surgery and administered by a dentist who has a permit to administer conscious sedation or general anesthesia
 - Apicoectomy
 - Hemi-section

Class III: Major Services

- Non-surgical periodontic services limited to once per 24 months: one full mouth treatment
 - Periodontal scaling and root planing
 - Gingival curettage
- Surgical periodontic services limited to once per 60 months
 - One full mouth treatment
 - Osseous surgery, including flap entry and closure
 - Gingivectomy and gingivoplasty
 - Limited or complete occlusal adjustments in connection with periodontal treatment
 - Mucogingival surgery limited to grafts and plastic procedures; one treatment per site
- Endodontics as required:
 - Root tip removal
 - Pulpotomy for deciduous teeth
 - Root canal for permanent teeth
 - Root canal retreatment performed on permanent teeth limited to once per tooth per lifetime
 - Root resection
- Major restorative services, limited to once per 60 months:
 - Dentures, full and/or partial
 - Fixed bridges, including crowns, inlays, and onlays used as abutments for or as a unit of the bridge
 - Crowns, inlays, onlays, and crown build-ups
 - Stainless steel crowns until the end of the year a member reaches age 19
- Dental implants and the hardware and services related to the placement of the implant following an extraction limited to once per 60 months
- Denture adjustments and relining limited to:
 - “Regular” dentures: once per 36 months, but not within six months of initial placement
 - “Immediate” dentures
 - Initial adjustment/relining after three months of placement
 - Second adjustment/relining within the first 12 months
 - Third adjustment/relining 36 months thereafter
- Recementation of crowns, inlays, and/or bridges, limited to once in any 12-month period
- Repair of prosthetic appliances, limited to once in any 12-month period per specific area of the appliance
- Maintenance of dental implants, limited to once in any 12-month period

Class IV – Orthodontic Services

Benefits for orthodontic services will be available to all plan members regardless of any treatment that may be in progress, except as specifically listed in this section.

Covered benefits include:

- The first and later installments of orthodontic services
- All orthodontic services/treatments that reduce or eliminate an existing malocclusion and associated oral diseases

The length of time for orthodontic services will be no more than 36 consecutive months of covered service. Twenty-five percent of the member's lifetime maximum for orthodontic services will be paid upon the initial placement of the bands. The remaining benefit will be divided into equal monthly amounts and paid out quarterly beginning when the dentist first provides covered services and ending on the first of the following events:

- Completion of the orthodontic services; or
- The end of the month in which services end for any reason other than completion, except as covered under the Extension of Benefits section of your plan documents; or
- When you reach the lifetime maximum for orthodontic services; or
- When the maximum allowed benefit for orthodontic services has been fully paid.

Limitations

The following limits apply on covered services:

- Covered dental services must be provided by or under the supervision of a dentist, practicing within the scope of practice for which he/she is licensed or certified.
- Benefits are limited to standard procedures and are not provided for personalized restorations or specialized techniques in the construction of dentures or bridges, including precision attachments and custom denture teeth.
- If you switch dentists during a course of treatment, or if more than one dentist provides services for one dental procedure, CareFirst will pay as if only one dentist provided the service.
- CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (does not apply to orthodontic services).
- If there are alternative dental procedures that meet generally accepted standards of professional dental care for a condition, benefits will be based upon the lowest cost alternative.

What's Not Covered

The following are not covered by the Dental PPO plan:

- 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.
- Services that are experimental/investigational or not in accordance with accepted medical standards in effect at the time the service in question is provided, as determined by CareFirst.
- Services or supplies which: were provided at no charge in any federal hospital, or through any federal, state or local governmental agency or department; were not your legal obligation; or are only charged to insured people. This exclusion does not apply to:
 - Medicaid;
 - Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland; or
 - Care received in a Veteran's hospital unless the care is provided for a condition resulting from military service.
- Services that are not specifically shown in CareFirst's Evidence of Coverage as a covered service or that do not meet all other conditions and criteria for coverage as determined by CareFirst.
- Cosmetic services.
- Treatment provided by a member of your family (parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew) or someone who resides in your home.
- All non-prescription drugs, medications, biologicals, and over-the-counter disposable supplies, unless specifically covered in CareFirst's description of covered services.
- Service furnished as a referral prohibited by law.
- Non-medical health care provider services, including, but not limited to:
 - Telephone consultations, charges for missed appointments, completion of forms, copying charges, or other administrative services.
 - Administrative fees charged by a health care provider to retain the health care provider's medical practice service, for example, concierge fees or boutique practice membership fees.
- Services related to an excluded service (even if they would otherwise be covered).
- Separate billings for services or supplies provided by an employee of a health care provider which are normally included in the health care provider's charges.
- Non-medical services, including, but not limited to: personal hygiene, cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators, and ramps.
- Personal comfort items.
- Services performed or prescribed by or under the direction of a person who is not a health care provider.
- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.
- Services provided through a dental or medical department of an employer, a mutual benefit association, a labor union, trust, or similar entity.
- Services provided or available under any worker's compensation, occupational disease, or employer's liability law, or any other similar law, even if you fail to claim benefits.
- Services provided or available through an agent of a school system due to the Individuals with Disabilities Education Act and Amendments, or any similar state or federal legislation, even if the services are normally covered when provided outside the educational domain.

- Illnesses resulting from an act of war.
- Charges used to satisfy your dental, prescription drug, or vision plan deductible, if applicable, or balances from any such programs.
- Oral surgery, dentistry, or dental processes, except as specifically covered by the plan.
- Routine and non-routine care of teeth, except as specifically covered by the plan.
- Outpatient prescription drugs unless otherwise stated.
- Replacement of a denture, bridge, or crown as a result of loss or theft.
- Replacement of an existing denture, bridge, implant, or crown determined by CareFirst to be satisfactory or repairable.
- Replacement of dentures, bridges, implants, or crowns within 60 months from placement or replacement, for which benefits were paid in whole or in part under the Plan.
- Treatment or services for temporomandibular joint disorders, including, but not limited to, radiographs and/or tomographic surveys.
- Gold foil fillings.
- Dental services in connection with birth defects or mainly for cosmetic reasons, with the following exceptions:
 - Benefits will be provided for dental services received due to trauma to whole, sound, natural teeth, only if your medical plan does not provide benefits for such dental services; and
 - Benefits will be provided for dental services in connection with birth defects, including cleft lip and/or cleft palate, only if your medical plan does not provide benefits for such dental services.
- Periodontal appliances.
- Prescription drugs, including, but not limited to, antibiotics that you take yourself, inhalation of nitrous oxide, injected or applied medications that are not part of the dental service being provided, and localized delivery of chemotherapeutic agents for the treatment of a medical condition, unless specifically listed as a covered dental service by the plan.
- Splinting.
- Nightguards, occlusal guards, or other oral orthotic appliances.
- Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a covered dental service by the plan.
- Intentional tooth reimplantation or transplantation.
- Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service, and tissue conditioning.
- Additional fees charged for visits by a dentist to your home, a hospital, a nursing home, or for office visits after the dentist's standard office hours. CareFirst will provide benefits for the dental service as if it had been provided in the dentist's office during normal office hours.
- Transeptal fiberotomy or vestibuloplasty.
- Orthognathic surgery or other oral surgery covered under your medical plan.
- Repair or replacement of any orthodontic appliance.
- Any orthodontic services after the last day of the month in which covered services ended except as specifically provided by the plan.
- Services or supplies related to excluded services (even if those services or supplies would otherwise be covered).

Claims Payment and Appeals

Participating Dentist

1. Claims will be submitted directly to CareFirst by the dentist.
2. CareFirst will pay benefits directly to the dentist.
3. You are only responsible for any applicable deductible and coinsurance or copay.

Non-Participating Dentist

1. Claims may be submitted directly to CareFirst or its designee by the dentist, or you may need to submit the claim. In either case, it is your responsibility to make sure claims are filed on time.
2. All benefits for covered services provided by a non-participating dentist will be payable to you or the dentist, at CareFirst's discretion.
3. In the case of a dependent child enrolled due to a court order or qualified medical child support order (QMCSO), payment will be made directly to the Department of Health and Mental Hygiene or the other parent (not the CareFirst member) if that parent has paid the provider.
4. You are responsible for any difference between CareFirst's payment and the non-participating dentist's charge.

You must file dental claims within 12 months after receiving care or as soon as reasonably possible (and except in the absence of legal capacity, no later than one year from the time proof was otherwise required). You will receive any reimbursement payable within 30 days after CareFirst receives your claim.

Claim Payments Made in Error

If CareFirst makes a claim payment in error, you are required to repay CareFirst. If you have not repaid the full amount you owe by the time CareFirst pays your next claim, CareFirst may subtract the amount you owe from the next payment.

Appeals

If the plan denies coverage, in whole or in part, for any services, you will be notified within 30 days after the claim for benefits is submitted unless there are special circumstances that require an extension of time for processing the claim. If you wish to appeal any denied claim, you can do so in writing within 180 days of the claim denial. You may submit written comments, documents, records, and any other information relating to the claim.

Assignment of Benefits

You may not assign your right to receive benefits or benefit payments to another person. The only exception is the usual practice of asking CareFirst to pay participating providers directly for services you receive.

For More Information

You can contact the dental plan at www.carefirst.com any time or by calling 1-866-891-2802, Monday through Friday, 8:30 a.m. to 5 p.m.

Your Vision Benefits

As a benefit-eligible employee, you may enroll in vision benefits to help cover the expenses of many different vision services and procedures. You may choose from two different vision plans:

- Basic Vision
- Vision Buy-Up Plan

How the Plans Work

Under both vision plan options, you and your eligible dependent(s) may receive certain vision care benefits, up to a scheduled amount. The vision plans are administered by National Vision Administrators (NVA). NVA boasts a nationwide network of optometrists, ophthalmologists, opticians, independent retailers, and optical retailers. This is just a summary of the vision plans. If there are any discrepancies between this description and the official plan documents, the official plan documents will determine benefits.

To receive vision benefits, follow these simple steps:

- Contact NVA at 1-800-672-7723 or go to <http://www.e-nva.com>.
- An NVA representative will verify eligibility for each member requesting vision care services and help you find a participating provider.
- Schedule an appointment with a vision care provider. You will pay less out of pocket if you see a provider who participates in the NVA network.

What's Covered

You and your eligible dependent(s) may receive vision exams and eyeglasses/contact lenses as listed below (from the last date of service).

Benefits When You See a Participating Provider

Vision Service	Basic Vision – Plan A (PSASA, Unaffiliated)	Basic Vision – Plan B (BTU, PSRP, L44, CUB)	Vision Buy-Up Plan
	Participating Provider	Participating Provider	Participating Provider
Benefits Frequency	Once every 24 months	Once every 24 months	Once every 12 months
Examination	100%	100%	100%
Lenses • Single vision • Bifocal • Trifocal • Lenticular • Standard Progressives • Blended Bifocal • Polycarbonates	• 100% • 100% • 100% • 100%	• 100% • 100% • 100% • 100%	• 100% • 100% • 100% • 100%
Frames	Up to \$130	Up to \$70	Up to \$130
Contact Lenses (in lieu of lenses and frames) • Elective • Medically Necessary	• Up to \$71* • 100%	• Up to \$45* • 100%	• Up to \$71* • 100%

* Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown.

Benefits When You See a Non-Participating Provider

Vision Service	Basic Vision – Plan A (PSASA, Unaffiliated)	Basic Vision – Plan B (BTU, PSRP, L44, CUB)	Vision Buy-Up Plan
	Non-Participating Provider	Non-Participating Provider	Non-Participating Provider
Benefits Frequency	Once every 24 months	Once every 24 months	Once every 12 months
Examination	Up to \$40	Up to \$31	Up to \$40
Lenses • Single vision • Bifocal • Trifocal • Lenticular • Standard Progressives • Blended Bifocal • Polycarbonates	• \$41.50 • \$67.00 • \$89.50 • \$156.50 • \$100.50 • \$100.50 • \$16.00	• \$26.00 • \$34.00 • \$47.00 • \$64.00 • \$40.00 • \$34.00 • \$16.00	• \$41.50 • \$67.00 • \$89.50 • \$156.50 • \$100.50 • \$100.50 • \$16.00
Frames	Up to \$47	Up to \$26	Up to \$47
Contact Lenses (in lieu of lenses and frames) • Elective • Medically Necessary	• Up to \$71 • Up to \$96	• Up to \$45 • Up to \$135	• Up to \$71 • Up to \$96

Examinations

The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test), and dilation (if professionally indicated).

Lenses

NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames

Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Lens Options

Lens options purchased from a participating NVA provider will be provided to you at the amounts listed below:

Lens Option	You Pay (at a participating NVA provider)
Solid Tint	\$10
Fashion/Gradient Tint	\$12
Standard Scratch-Resistant Coating	\$10
Ultraviolet Coating	\$12
Standard Anti-Reflective	\$40
Glass Photogrey (Single Vision)	\$20
Progressive Lenses Premium	\$100
Transitions Single Vision Standard	\$65
Transitions Multi-Focal Standard	\$70
High Index	\$55
Polarized	\$75
Glass Photogrey (Multi-Focal)	\$30

For lens options and services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the provider's U&C price. Fixed prices are available in-network only. Discounts are not insured benefits. In Maryland, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

Laser Eye Surgery

NVA has chosen The National LASIK Network to serve their members. This network was developed by LCA Vision in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Contact Lenses

The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable, and disposable lenses. Medically necessary contact lenses include fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia, or Keratoconus.

Non-Participating Providers

You will be responsible for 100% of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID number, and sponsoring organization to:

NVA
P.O. Box 2187
Clifton, NJ 07015

What's Not Covered

No payment is made for any of the following conditions, procedures, and/or materials, unless otherwise specifically listed as a covered benefit:

- Replacement frames and/or lenses, except at normal intervals when covered services are otherwise available;
- Plano or non-prescription lenses or sunglasses;
- Orthoptics, vision training and any associated supplemental testing;
- Frame cases;
- Low (subnormal) vision aids or aniseikonic lenses;
- Medical and surgical treatment of the eyes;
- Charges incurred after (a) the policy ends; or (b) the insured's coverage under the policy ends, except as stated in the policy;
- Any eye examination or corrective eyewear required by an employer as a condition of employment;
- Services and materials provided by another vision plan;
- Services for which benefits are paid by worker's compensation;
- Blended bifocal lenses;
- Groove, drill or notch, and roll and polish;
- Two pairs of glasses, in lieu of bifocals, trifocals, or progressives;
- Coating on lenses (factory scratch coat, anti-reflective, sunglass colors, etc.);
- Cosmetic items (determination of what is or is not considered a "cosmetic item" will be made solely by the treating provider);
- Faceted lenses;
- High-index lenses;
- Laminated lenses;
- Oversize lenses – any lens with an eye size of 61mm or greater;
- Photochromic (transition) lenses;
- Polaroid lenses;
- Polished bevel lenses;
- Polycarbonate lenses;
- Prism lenses;
- Slab-off lenses;
- Tints (except Pink tint #1 and #2);
- Ultra-violet tint or coating;

- Additional cost for contact lenses over the allowance;
- Additional cost for a frame over the allowance; or
- Progressive lenses.*

*Progressive Lens Benefit. If this type of lens is not a covered benefit under your certificate, the provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens You have selected. You pay the provider the difference, if any, between the two.

Participating Providers are not contractually obligated to offer sale prices in addition to insurance coverage. Regardless of medical or optical necessity, proposed vision benefits are not available more frequently than specified in the policy.

Claims Payment

When you use NVA participating providers, the provider will file the claim on your behalf; there is nothing that you need to do. However, if you use a non-participating provider, you must pay for the full cost at the time of service, file your own claim, and send it along with an itemized receipt directly to NVA for reimbursement. For reimbursement according to your plan, you can download a claim form from the NVA website and submit it along with a copy of the itemized receipt and with a letter containing your name, member's identification number, or a photocopy of your identification card to:

NVA
P.O. Box 2187
Clifton, NJ 07015

Note: If the expenses for the exam, lenses, frames, or contact lenses exceed the amount in the schedule of vision care benefits, you will be responsible for any additional cost above the NVA allowance.

NVA Definitions

Administrator – The entity which provides complete service and facilities for the writing and servicing of the policy as agreed to in a contract with NVA.

Claim – A request for payment of benefits under this plan.

Copay – An insured's share of the costs that are incurred by an in-network provider. The copay is paid directly to the provider at the time services are rendered. If an out-of-network provider is used, the copay, if any, will be deducted from the out-of-network allowance at the time NVA pays benefits. Copay amounts are listed in the schedule of benefits.

Contact Lenses, Elective – Elective contact lenses refer to contact lenses an insured chooses to wear instead of eyeglasses for reasons of comfort or appearance.

Contact Lenses, Non-Elective – Non-elective contact lenses refer to contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the insured from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.

- Aphakia (after cataract surgery). A pair of prescription single vision or multifocal eyeglass lenses and an eye frame can be provided in addition to non-elective contact lenses for this condition.
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses (must be 20/60 or better).
- Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
- Keratoconus.

Reimbursement of non-elective contact lenses will be considered as payment in-full if utilizing the services of an in-network provider.

Covered Dependent – Means an eligible dependent who is insured under this plan.

Covered Vision Exam or Materials – Means the vision exam or materials that qualify for benefits under the group policy. Covered vision exam or materials are shown in the schedule of benefits and in the supplement to schedule of benefits.

Eligible Class – Means the group of people who are eligible for coverage under the group policy. The members of the eligible classes are shown in the certificate schedule. Each member of the eligible class will qualify for insurance on the date he/she completes the required waiting period, if any.

Eligible Dependent – Means a person listed below:

- Your spouse;
- Your child under age 26, who is your natural or legally adopted child, step-child, grandchild who is in your court-ordered custody, or an individual for whom guardianship is granted by a court or testamentary appointment (other than temporary guardianship of less than 12 months duration) and who is primarily dependent on you for support and maintenance.
- Your unmarried child who has reached age 26 and who is:
 - primarily dependent upon you for support and maintenance; and
 - incapable of self-support by reason of mental or physical incapacity.

Proof of the child's incapacity or dependency must be furnished to NVA for an already enrolled child who reaches the age limitation, or when you enroll a new disabled child under the plan.

Eyeglass Lenses – A standard glass or plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.

Immediate Family Member – An insured's parent, step-parent, spouse, child, step-child, brother, or sister.

Initial Term – The period following the group's initial effective date and shown in the certificate schedule. rates are guaranteed not to change during this period, subject to the premium adjustments provision.

In-Network Provider - An ophthalmologist, optometrist, or optician who has entered into an agreement with the administrator to provide the covered vision exam or materials at an agreed to cost. When an in-network provider is used, the Insured will generally incur less out-of-pocket cost for the services rendered.

In-Network Provider Directory – A list of in-network providers and the services they are contracted for in your area. The list will be updated periodically.

Insured – Means a person for whom insurance under the policy has become effective.

Late Entrant – Any member or eligible dependent enrolling more than 31 days after first becoming eligible for coverage. Benefits may be limited for late entrants.

Materials – Means corrective eyeglass lenses, frames, and contact lenses.

Member – Means a person who belongs to an eligible class of the policyholder.

Ophthalmologist – A person who is licensed by the state in which he or she practices as a doctor of medicine or osteopathy and is qualified to practice within the medical specialty of ophthalmology. The ophthalmologist cannot be 1) the insured; 2) an immediate family member; or 3) retained by the policyholder.

Optician – A person or business that grinds and/or dispenses eyeglass lenses and contact lenses prescribed by either an optometrist or ophthalmologist. The optician cannot be: 1) the Insured; 2) an immediate family member; or 3) retained by the policyholder. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist – A person licensed to practice optometry as defined by the laws of the state in which services are rendered. The optometrist cannot be 1) the insured; 2) an immediate family member; or 3) retained by the policyholder.

Out-of-Network Provider – An ophthalmologist, optometrist, or optician who is not an in-network provider. These providers have not entered into an agreement with NVA to limit their charges. They are not listed in the in-network provider directory.

Plano Lens – A lens that has no refractive power.

Policyholder – The entity stated on the front page of the policy.

Rolling Benefit Plan – Benefits begin anew 12 or 24 months from the date of service.

Spouse – Your legally recognized spouse in the state where you reside.

Vision Exam – An examination of principal vision functions. A vision exam includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing, and tonometry, if indicated. The exam must be consistent with the community standards, rules, and regulations of the jurisdiction in which the provider's practice is located.

Waiting Period – The period of time a member must wait before any Insured is eligible for coverage. The waiting period, if any, is specified in the policyholder's group application and shown in the certificate schedule.

For More Information

To learn more about NVA, go to www.e-nva.com

Your Employee Assistance Program (EAP)

The Employee Assistance Program (EAP), offered by City Schools through ComPsych® GuidanceResources®, is designed to help you balance your responsibilities at work and in your personal life. The EAP is available to all City Schools employees whether they elect the employer medical plan or not. It is provided at no cost to employees and household members. Household members are defined as those residing in your household and eligible dependents away at school.

How it Works

The EAP offers counseling, legal and financial consultation, work-life assistance, and crisis intervention services to all our employees and their household members. The EAP covers up to six sessions per issue at no cost to you. Your EAP benefit provides practical solutions, information, resources, and support for a wide range of work-life issues including, but not limited to, anxiety, depression, child or senior care, relationship or marital issues, alcohol or substance abuse, finding colleges, bereavement, financial or legal concerns, and parenting challenges. Your EAP can help you handle problems that affect your physical and mental wellbeing, as well as your relationships. It offers confidential access 24 hours a day, 365 days a year to trained professionals who can discuss your question, problem, or concern.

Accessing Services

You can reach the EAP by phone at 855-388-4255 (TRS dial 711), 24 hours a day, seven days a week or online at guidanceresources.com (Web ID: CitySchools). You can also download the GuidanceNowSM app for on-the-go support.

The first time you use GuidanceResources online, follow these steps:

- Go to guidanceresources.com and click the Register tab.
- Enter your Organization Web ID (CitySchools) and click the Register button.
- You will then be asked to enter a User Name and Password. Both can be anything you would like them to be but should be something you will remember. The User Name (often your name) must be at least six characters long and should have no spaces (for example: joesmith). The Security Questions are meant to prompt you if you forget your password. You must select the button verifying that you are at least 13 years of age, as required by federal law. Be sure to read the Terms of Use and click inside the check box to indicate your agreement to those terms. Make sure that you complete all fields that have red asterisks, as these are required fields. When you've finished, click the Submit button at the bottom of the page. You should now be on the website.

If you have any problems registering or logging into GuidanceResources Online, email Member Services at memberservices@compsych.com.

What is Covered

Depending on your situation, the EAP counselor may assist by:

- Referring you to a licensed network EAP provider in your community.
- Linking you to available resources in your community
- Offering you EAP support over the telephone.

Additionally, if the counselor determines the situation requires it, you may be referred for additional assistance through the mental health or substance abuse coverage offered through your medical plan.

Any information about your call or treatment is confidential and may only be disclosed as permitted or required by law.

Work/Life Services

Balancing work, life, and family responsibilities is no easy task. Employees and family members must constantly juggle competing demands, from making deadlines to running errands to finding quality child care and caring for aging relatives. The EAP can provide extensive assistance, information, and support to you, helping you to achieve a better balance between home and work.

The EAP covers a variety of needs and programs or services for any circumstance. The scope of the EAP includes (but is not limited to):

- Adoption
- Parenting and child development
- Child care
- Emergency dependent care
- Education
- Children and adults with special needs
- Convenience services
- Moving and relocation
- Pet care
- Health and wellness
- Older adult care
- Aging
- Retirement
- End-of-life issues
- Balancing work and family

Legal and Financial Solutions

The EAP also provides access to a national network of independent attorneys who have experience in a variety of legal areas including bankruptcy, estate planning, taxes, family law, consumer and financial matters, and traffic violations. Contact ComPsych GuidanceResources for more information.

Reimbursement of Claims

You do not have to file EAP claims. There are no copays, coinsurance, or deductibles. You should not make any payment to a provider for EAP services. You should not make any agreement with an EAP counselor to pay the counselor for EAP services. However, you will be responsible to pay for services that you obtain without receiving prior authorization for an EAP case with a particular EAP counselor.

When Coverage Ends

You can contact the EAP for services up to 30 days after separation from Baltimore City Schools. ComPsych GuidanceResources will honor all existing EAP authorizations.

For More Information

You can reach the EAP by phone at 855-388-4255 (TRS dial 711), 24 hours a day, seven days a week or online at guideanceresources.com (Web ID: CitySchools). You can also download the GuidanceNowSM app for on-the-go support.

Your Flexible Spending Accounts

You may choose from two different flexible spending accounts:

- Medical Care Flexible Spending Account (FSA)
- Dependent Care Flexible Spending Account (FSA)

These accounts are administered by P&A.

How the FSAs Work

While Baltimore City Public Schools offers a number of benefits to meet many of your needs, even the best plans do not cover all expenses, such as medical copayments and deductibles or child or elder care. By setting up a Medical Care FSA or Dependent Care FSA, you can pay for certain eligible health or dependent care expenses on a before-tax basis.

The FSAs allow you to reduce your annual taxable income to help you pay for certain eligible expenses with before-tax dollars. This saves you money because you pay less income tax.

Here is how it works:

- During each annual enrollment period, you decide if you want to use a Medical Care FSA, a Dependent Care FSA, or both in the upcoming calendar year;
- Then, you estimate your eligible expenses for the plan year (calendar year) and determine the amount you wish to set aside in your FSA(s);
- This amount will be automatically deducted from your pay throughout the year and credited to your account; and
- When you have an eligible expense:
 - Use your P&A Benefits Mastercard to pay for eligible medical expenses at the time of service, if eligible; or
 - File a claim for reimbursement from your account with P&A.

The advantage of these accounts is that your contributions are conveniently deducted from your paychecks. And, these deductions are made before most federal, state/local, and Social Security taxes are calculated. This means your contributions are made on a before-tax basis. However, if you live in New Jersey, contributions to your Dependent Care FSA are subject to state tax.

Contribution Amounts

When you sign up for an FSA, you decide how much money to put into your accounts for the year, up to federal government limits listed below. The annual amount you elect will be deducted throughout the year from each paycheck in equal amounts before taxes.

Flexible Spending Account Type	Maximum Annual Contributions
Medical Care FSA	\$3,400
Dependent Care FSA	\$7,500 if married and filing jointly \$2,500 if married and filing separately

When you have eligible out-of-pocket expenses, submit receipts with a reimbursement form to P&A for reimbursement, or use your P&A Benefits Mastercard at the time of service.

Medical FSA

Eligibility for a Medical Care FSA

You may set up a Medical Care FSA if you are an active employee of Baltimore City Public Schools who is eligible to receive benefits. You do not need to be a participant in one of the Baltimore City Public Schools medical, dental, or vision plans to participate.

Eligible Dependents

For the purposes of the Medical Care FSA, eligible dependents are limited to:

- Those individuals you claim on your income tax return;
- Those individuals you could have claimed as a dependent on your return except that the person filed a joint return, had gross income of \$3,700 or more, or could be claimed as a dependent on someone else's prior year tax return; or
- Your child under age 27 at the end of your tax year.

Eligible Expenses for a Medical Care FSA

The following is a list of medical expenses that can be paid with before-tax dollars from the Medical Care FSA. This list is not all-inclusive and is only meant to provide examples. For a complete list, refer to <https://www.fsafeds.com/explore/hcfsa/expenses>.

- Acupuncture
- Alcoholism treatment
- Ambulance hire
- Artificial teeth/dentures
- Bandages
- Blood pressure monitors
- Braces
- Braille-books and magazines
- Breast pumps and lactation supplies
- Cancer screening
- Chiropractors
- Coinsurance amount you pay
- Copay amount you pay
- Condoms
- Contact lenses and eyeglasses
- Contact lens solutions
- Cold/Hot Packs
- Cost of operations and related treatments
- Crutches
- Deductible medical coverage (amounts you pay)
- Dental fees
- Diabetic supplies
- Drug addiction treatment
- Eye exams, eye glasses, eye surgery

- Fertility treatments (in vitro fertilization, surgery)
- Guide dog/service animal (including purchase, maintenance)
- Intellectually/developmentally disabled person's school and education (i.e., payments made for a mentally impaired or physically disabled person to attend a special school including tuition, meals and lodging)
- Hearing devices and batteries
- Hospital services
- Incontinence products
- Insulin
- Laboratory fees
- Lead-base paint removal (for children with lead poisoning)
- Medical alert bracelets
- Medical information plan
- Mentally handicapped persons cost of special home care
- Nurses fees (including nurses' board and social security tax paid by you)
- Obstetrical expenses
- Operations
- Oxygen
- Prosthesis
- Pregnancy tests
- Psychiatrists' and psychologists' fees
- Radial keratotomy and Lasik eye surgery
- Rolfing therapy
- Routine physical & other non diagnostic services or treatments
- Smoking cessation programs
- Speech Therapy
- Special education for the blind
- Special plumbing for handicapped
- Sterilization (i.e., tubal ligation, vasectomy)
- Surgical fees
- Telephone, special for hearing impaired
- Television audio display equipment for hearing impaired
- Therapeutic care for drug and alcohol addiction received as medical treatment
- Thermometers
- Transportation expenses for person to receive medical care
- Vaccines
- Walkers
- Wheelchair
- X-rays

Ineligible Expenses for a Medical Care FSA

Following is a list of expenses that are not eligible for reimbursement from the Medical Care FSA. This is not a complete list.

- Amounts paid for health insurance premiums
- Amounts paid for long-term care coverage or expenses
- Amounts that are covered under another health plan
- COBRA premiums
- Concierge service fees
- Cosmetic products and cosmetic surgery (unless to remediate damage from an illness or injury)
- Disposable diapers
- Diet program foods
- Electrolysis
- Feminine hygiene products
- Fitness programs*
- Hair transplants*
- Hand sanitizer
- Household help
- Maternity clothes
- Teeth whitening*

* Unless prescribed by a doctor to treat an existing illness or injury.

Dependent Care FSA

Eligibility for a Dependent Care FSA

You may set up a Dependent Care FSA if you are an active employee of Baltimore City Public Schools who is eligible to receive benefits. You also must have an eligible dependent, as defined in the next section. One of the following must also apply:

- You are a single parent;
- Your spouse works;
- Your spouse attends school full-time at least five months during the year (while you are working);
- Your spouse is disabled and cannot care for himself or herself; or
- You have a disabled adult dependent living with you, such as a parent, brother, or sister.

Eligible Dependents

For the purposes of the Dependent Care FSA, eligible dependents are limited to those individuals you claim on your income tax return and must be at least one of the following:

- A person under age 13 who is your qualifying child under the Internal Revenue Code:
 - He or she has the same principal residence as you for more than half the year;
 - He or she is your child or step-child (by blood or adoption), foster child, sibling or step-sibling, or a descendant of one of them; and
 - He or she does not provide more than half of his or her own support for the year.

If you are divorced or separated, you must be the primary custodial parent of your child in order to be eligible for this account (irrespective of whether which parent may claim a personal exemption for the child on his or her federal income tax return). Non-custodial parents may wish to check with your legal or tax advisor to see if special rules apply to you that would enable you to utilize this account.

- Your spouse if he or she is physically or mentally incapable of self-care and has the same principal abode as you for more than half the year.
- A person who is physically or mentally incapable of self-care, has the same principal abode as you for more than half the year and is your tax dependent under the Internal Revenue Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the code's definition).

Eligible Expenses for a Dependent Care FSA

The following is a list of dependent care expenses that can be paid with before-tax dollars from the Dependent Care FSA. This list is not all-inclusive and is only meant to provide examples. For a complete list, refer to <https://www.fsafeds.com/explore/dcfsa/expenses>.

- Babysitters
- Daycare centers
- Nursery schools
- After-school programs
- Day camp
- Eldercare

Ineligible Expenses for a Dependent Care FSA

Expenditures that are prohibited for reimbursement include the following:

- Babysitting for social events
- Educational expenses
- Charges for overnight camp
- Expenses that you will take as a child care tax credit on your income tax return
- Expenses for services provided by your spouse, by a parent of your under-age-13 qualifying child or by a person for whom you or your spouse is entitled to claim a personal exemption on a federal income tax return

Tax Credit versus Dependent Care FSA

One issue to consider before you open a Dependent Care FSA is whether you should take the tax credit for child care on your personal income tax return or use the Dependent Care FSA. Expenses reimbursed from a Dependent Care FSA may not be used as a federal income tax credit. You do not have the option of claiming the full amounts of both the tax credit and the FSA.

The limit on the tax credit is \$3,000 for one dependent or \$6,000 for two or more dependents. If you use a combination of the tax credit and the Dependent Care FSA, the tax credit will be reduced for every dollar you place in the Dependent Care FSA. Consult a tax advisor for more information. You will determine which is better for your own tax circumstances by estimating your taxes using each method. Generally, you may want to choose the Dependent Care FSA if:

- Your annual family income from pay, interest, and other sources will be greater than \$39,000 after pre-tax deductions; or
- Your annual family income from pay only will be greater than \$13,730 after pre-tax deductions (\$14,730 if you are married filing jointly), AND either:
 - You'll be eligible for the Earned Income Tax Credit and you have at least one dependent child; or
 - You'll have dependent care expenses for only one dependent and your expenses will be more than \$3,000.

You should consult a tax advisor to find out how to maximize your tax savings, based on your specific tax situation.

Enrolling In an FSA

There are no refunds for erroneous election into either Flexible Spending Account. Therefore, it's important that you only enroll in the Medical Care FSA and/or Dependent Care FSA if you are sure you want to participate.

Enrolling as a New Employee

You are eligible to open a Medical Care FSA or Dependent Care FSA on your first day of service with City Schools or during open enrollment. As a new employee, you must complete a Benefit Selection Form, which is available online. To qualify for benefits, you must return your Benefit Selection Form within 30 calendar days from your date of employment. Upon receipt of your completed enrollment form, it will take one to two pay periods to process your enrollment request. The annual amount you elect will be divided into the remaining pay periods of the calendar year. If you do not return an enrollment form within the specified time frame, you will not be eligible to participate until the next open enrollment period.

IMPORTANT: You cannot be reimbursed for expenses that occur before the effective date.

Re-enrolling Each Open Enrollment Period

Each year during open enrollment, you will be given the opportunity to enroll (or re-enroll) in the Medical Care FSA and Dependent Care FSA for the next plan year. Please follow the instructions in your open enrollment materials to enroll for the next plan year.

Enrolling Mid-Year Due to a Qualifying Event

Once you designate an amount for the Medical Care FSA and Dependent Care FSA, you cannot change this amount until the next open enrollment period unless you have a qualifying event. Some examples of qualifying events include:

- Birth of a child;
- Loss of a dependent;
- Marriage;
- Divorce;
- A change in dependent day care fees;
- Your dependent child reaching age 13, and no longer qualifying for dependent day care reimbursement under your Dependent Care FSA; and
- Termination of your spouse's employment.

You have 30 days from the date of the qualifying event to make changes to your benefits. The changes you request must be "pertaining to and consistent with" the qualifying event which occurred.

Even though the amount you set aside in the FSAs is not designated for a specific person in your household or a specific expense, a change in one dependent's status may not necessarily justify changes to an FSA.

Therefore, the circumstances under which mid-year changes to the Medical Care FSA and Dependent Care FSA are permitted are very limited. If you already have an FSA, contact P&A to determine if your situation enables you to make a change to your FSA, otherwise contact the Department of Employee Services. To make a change, fill out a Benefit Selection Form.

Important IRS Rules

Although the FSAs provide real advantages, there are some important IRS rules and restrictions you should know about:

- These accounts have a use-it-or-lose-it rule. Any money left over in your account at the end of the year cannot be carried over into the next year or returned to you. According to federal law, you have to forfeit the remaining balance left in your account. You do have until March 31 of the following year to submit expenses you had during the previous year. But after March 31, any money left over is lost. That is why it is very important to conservatively estimate your eligible health care and/or dependent care expenses for the coming year and plan your contributions carefully.
- If you still have monies left over in your account and no eligible expenses from the prior year, you may use the monies from the prior year to pay for expenses incurred from January 1 through March 15th. Claims must be submitted no later than April 30th to P&A.
- The amount you elect to deposit into your Medical Care FSA or Dependent Care FSA cannot be changed after the Plan Year starts, unless you have a qualifying event. Check your confirmation statement and January pay stubs to be certain that your deduction amounts are correct. The only changes that will be made are those to correct processing errors made by the City Schools.
- The Medical Care FSA may only be used for eligible health care expenses and the Dependent Care FSA may only be used for eligible dependent care expenses. You may not use funds deposited in the Medical Care FSA to pay for expenses eligible under the Dependent Care FSA, and vice versa.

Minimum and Maximum Contributions

There are minimum and maximum contributions for the FSAs. You can contribute any amount that falls between the following limits:

Medical Care FSA*

	Minimum Contribution Limit	Maximum Contribution Limit
Annually	\$120.00	\$3,400.00
Bi-Weekly	\$4.62	\$130.77
21 Pays	\$5.71	\$161.90

*There is an exception to the Medical Care FSA contribution limit:

- If your spouse is also eligible to participate in a Medical Care FSA, either with Baltimore City Public Schools or another employer, the combined amount you both contribute cannot exceed \$2,500.

Dependent Care FSA**

	Minimum Contribution Limit	Maximum Contribution Limit
Annually	\$120.00	\$5,000.00
Bi-Weekly	\$4.62	\$288.46
21 Pays	\$5.71	\$357.14

**There are a few exceptions to the Dependent Care FSA contribution limit:

- If you are married and have a working spouse, the amount you put into this account cannot exceed the lower of your two earned incomes. For example, if your spouse works part-time and earns \$4,000 a year, you can only put up to \$4,000 in your Dependent Care FSA.
- If you are married and filing separate returns, the amount each of you can contribute to an employer-sponsored Dependent Care FSA is \$2,500.
- If your spouse is also eligible to participate in a Dependent Care FSA, either with Baltimore City Public Schools or another employer, the combined amount you both contribute cannot exceed \$7,500.

If You Are on Short-term or Long-term Leave of Absence without Pay

If you are on an unpaid leave of absence, you may qualify to stop FSA deductions for the remainder of the year. Like any qualified event, you must notify the Department of Employee Services within 30 days of the qualifying event and complete a Benefits Enrollment Form to stop all future deductions.

If you decide to discontinue your deposits to your Medical Care FSA or Dependent Care FSA, you are shortening your coverage period, and you may obtain reimbursement only for expenses incurred during that shortened coverage period.

Receiving Reimbursement from Your FSAs

If you participate in a Medical Care FSA, you have two ways to receive reimbursements from your account:

- Use your P&A Benefits Master Card; or
- File a claim for reimbursement.

If you participate in a Dependent Care FSA, you must file a claim for reimbursement.

Keep Your Receipts

Save all of your Medical Care FSA receipts and other supporting documentation. IRS rules require us to verify the eligibility of purchases made with your benefit card. You may receive a P&A notice asking you to verify a transaction.

Flexible Spending Account Definitions

Annual election amount – this is the total dollar amount you elect to put into your FSA at the beginning of each plan year.

Dependent – a person whose expenses are eligible for reimbursement through the employee's FSA. A dependent is usually an employee's spouse or child(ren) under age 27. Please visit the website at www.padmin.com for more information.

Eligible expense – items that are reimbursable under the FSA Plan are classified as eligible expenses according to IRS rule.

FICA – taxes collected for Social Security and Medicare benefits.

Flexible Spending Account – also known as an FSA; a pre-tax benefit plan that enables the employee to save 30-40% on eligible expenses. By enrolling in this plan, the participant saves on state (except in New Jersey), federal, and FICA taxes.

Grace period – an employer-chosen extension of the plan during which expenses can be incurred.

Medical Care FSA rollover – an employer-chosen provision allowing up to a maximum of \$500 of unused Medical Care FSA funds to roll over into the next plan year.

Open enrollment – a designated time, prior to the start of your plan year, during which employees can enroll in the FSA plan and change their benefit elections.

Plan year – the twelve-month period during which the annual election is effective.

Run-out period – a period of time after the plan year ends during which participants may submit receipts for expenses that were incurred during the plan year or grace period.

Uniform Coverage Rule – this rule allows you to access your entire annual election for the Health FSA immediately after the start of the plan year. All other accounts are "pay-as-you-go." This rule only applies for the Health Flexible Spending Account.

Use-or-Lose Rule – an IRS rule, which states that employees must spend any remaining balance in their FSA by the end of the plan year. If you don't spend the money, you forfeit it.

For More Information

If you have questions about your Flexible Spending Accounts, contact P&A at 1-800-688-2611 or visit www.padmin.com.

Life and Accidental Death and Dismemberment (AD&D) Insurance

Basic Employee Life and AD&D Insurance

Basic Life Insurance entitles your beneficiary(ies) to a benefit in the event of your death as an active eligible employee. Accidental Death and Dismemberment (AD&D) covers you for loss of limbs and/or sight caused or your death caused directly by an accident. City Schools pays 100% of the cost for your Basic Life and AD&D coverage.

If you are a member of BTU, PSRP, PSASA, or the Unaffiliated group, you are eligible to receive this benefit beginning the first of the month following your date of hire, provided you are considered a benefit-eligible employee on your date of hire. If you are a member of CUB or AFSCME Local 44, you are eligible to receive this benefit the first of the month following 12 months of consecutive service.

Coverage Amounts

Like eligibility, your coverage amount also depends upon your union affiliation, as described next:

Benefits for Active Baltimore Teachers Union Employees (BTU) After One Month of Service		
Employee Class	Basic Life Insurance	Accidental Death and Dismemberment Insurance
All BTU Full-time Benefit Eligible Employees	\$70,000	\$70,000
All Part-time Benefit eligible BTU Employees	A percentage of \$35,000, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.	A percentage of \$35,000, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.

Benefits for Active Public School Administrators (PSASA) After One Month of Service		
Employee Class	Basic Life Insurance	Accidental Death and Dismemberment Insurance
All PSASA Full-time Employees	1 times your base annual salary, as determined by City Schools	1 times your base annual salary, as determined by City Schools
All Part-time PSASA Employees	A percentage of your base annual salary, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.	A percentage of your base annual salary, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.

Benefits for Active Professional School Related Personnel Employees (PSRP) After One Month of Service		
Employee Class	Basic Life Insurance	Accidental Death and Dismemberment Insurance
All PSRP Full-time Benefit Eligible Employees	1 times your base annual salary, as determined by City Schools or \$27,000, whichever is greater	1 times your base annual salary, as determined by City Schools or \$27,000, whichever is greater
All Part-time Benefit eligible PSRP Employees	A percentage of your base annual salary, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.	A percentage of your base annual salary, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.

Benefits for Active Unaffiliated Employees (GSS) After One Month of Service		
Employee Class	Basic Life Insurance	Accidental Death and Dismemberment Insurance
All GSS Full-time Employees	2 ½ times your base annual salary, as determined by City Schools	2 ½ times your base annual salary, as determined by City Schools
All Part-time GSS Employees	A percentage of your base annual salary, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.	A percentage of your base annual salary, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.

Benefits for Active City Union of Baltimore Employees (CUB) After One Year of Service		
Employee Class	Basic Life Insurance	Accidental Death and Dismemberment Insurance
All CUB Full-time Employees	1 times your base annual salary, as determined by City Schools	1 times your base annual salary, as determined by City Schools
All Part-time CUB Employees	A percentage of your base annual salary, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.	A percentage of your base annual salary, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.

Benefits for Active Local 44 Employees (L44) After One Year of Service		
Employee Class	Basic Life Insurance	Accidental Death and Dismemberment Insurance
All L44 Full-time Employees	1 times your base annual salary, as determined by City Schools	1 times your base annual salary, as determined by City Schools
All Part-time L44 Employees	A percentage of your base annual salary, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.	A percentage of your base annual salary, as determined by City Schools. The percentage corresponds to the percent of time (of a full-time employee) that you work.

How to Designate a Beneficiary

Please note that you must record your Life and Accidental Death and Dismemberment beneficiary, who is the person (or persons) you designate to receive benefit payments in the event of your death. The Hartford offers a simple way to update your beneficiary. Go to the secure website to designate your beneficiaries online: enroll.thehartfordatwork.com/bcpsbene. If you are enrolling for the first time, enter the following information:

- User ID: Your initials of your first and last name, followed by the last four digits of your Social Security Number.
- Password: Your initials of your first and last name followed by your date of birth (MMDDYYYY).

For example, if your name is John Doe, born on January 1, 1970, with last four digits of your Social Security Number being 1234, your login information is:

- User ID: jd1234
- Password: jd01011970

Customer service representatives are available to walk you through the log in process should you need help. Please call 855-EZ-NROLL (1-855-396-7655) Monday through Friday from 8 a.m. to 8 p.m., ET.

Conversion Privilege

If your coverage through City Schools ends for any reason, you may be eligible to continue an individual life insurance policy with The Hartford insurance company. This policy can be in an amount equal to or less than the amount of life insurance you had under City Schools' policy. You will not have to provide proof of good health to receive this coverage. You are responsible for paying the full premium for this coverage. You have 31 days from the date your coverage ends to convert your policy.

How to File a Claim

Upon your death, your designated beneficiary(ies) should contact The Hartford within 30 days to file a claim. Your beneficiary can contact The Hartford at 1-888-563-1124.

For More Information

To learn more about your Basic Life and Accidental Death & Dismemberment Plan, go to www.TheHartford.com/mybenefits or call 1-888-563-1124.

Basic Dependent Life Insurance

If you are covered under the Basic Life and Accidental Death and Dismemberment Plan and are a member of one of the following unions, your eligible dependents are automatically covered under the Basic Dependent Life Insurance Plan at no cost to you:

- Baltimore Teachers Union (BTU)
- Active Public Schools Administrators (PSASA)
- Active Professional School Related Personnel Employees (PSRP)
- Active Unaffiliated Employees (GSS)

The Basic Dependent Life Insurance Plan provides your eligible dependent(s) with life insurance coverage that would be paid to you in the event of his/her death.

Your dependents' coverage automatically begins the first day on which you have enrolled for coverage and all of these conditions are met:

- The person is your qualified dependent;
- You are eligible for Basic Dependent Life Insurance coverage;
- You are covered under the Basic Life Insurance plan; and
- The plan has not been discontinued.

Coverage Amounts

Coverage is available for your eligible dependents as follows:

- Your spouse: \$2,000
- Your children age 14 days or over, but less than 6 months: \$200
- Your children age 6 months or over, but less than 25 years: \$1,000

Qualified Dependents

Your dependents are eligible for the Basic Dependent Life Insurance plan while you are eligible for the Basic Life and Accidental Death and Dismemberment plan and if they are considered to be a qualified dependent under the plan. Your qualified dependents include:

- Your spouse; and
- Your unmarried children, stepchildren, legally adopted children, or any other children related to you by blood or marriage who are age 26 or younger or age 26 or older and disabled, and:
 - Live with you in a regular parent-child relationship; and/or
 - You claimed as a dependent on your last filed federal income tax return provided such children are primarily dependent upon you for financial support and maintenance.

A child can only be considered the qualified dependent of one City Schools employee.

Beneficiary

You are automatically the beneficiary for your qualified dependent's Basic Dependent Life Insurance plan.

How to File a Claim

Upon your dependent's death, you should contact The Hartford within 30 days to file a claim. Your beneficiary can contact The Hartford at 1-888-563-1124.

For More Information

To learn more about your Basic Dependent Life Insurance plan, go to www.TheHartford.com/mybenefits or call 1-888-563-1124.

Optional Employee Life and AD&D Insurance

To supplement your Basic Life and AD&D coverage, you can choose to enroll in the Optional Life and Accidental Death and Dismemberment (AD&D) plan.

The Optional Life and Accidental Death and Dismemberment plan provides you with additional life insurance and AD&D coverage beyond what your Basic Life plan covers. AD&D insurance provides benefits in the case of death or loss of limbs or sight caused directly by an accident.

Coverage Amounts

When enrolling in the Optional Life and AD&D Plan, you may choose a level of coverage equal to one, two, three, four, or five times your annual salary (rounded to the next highest \$1,000) up to a maximum of \$750,000 (this is a combined maximum with Optional Life).

Proof of Good Health

When enrolling in the Optional Life and AD&D Plan for the first time, you must provide a proof of good health form to The Hartford before your coverage will become effective.

If you wish to increase your coverage during open enrollment, you may increase your coverage amount by one times your salary without a proof of good health form. For any increases more than one times your salary, you will need to complete and return a proof of good health form to The Hartford before your coverage will become effective.

Coverage Rates

Your Age	Voluntary Life Insurance Rate per Thousand	Voluntary AD&D Insurance Rate per Thousand
Under 30	\$0.041	\$0.015
30 – 34	\$0.048	
35 – 39	\$0.054	
40 – 44	\$0.082	
45 – 49	\$0.136	
50 – 54	\$0.230	
55 – 59	\$0.375	
60 – 64	\$0.579	
65 – 69	\$0.953	
70 – 74	\$1.859	
75 and up	\$2.060	

Please Note: Your coverage rates for Optional Life insurance coverage may change during the plan year if:

- Your age changes after January 1 and you move to a higher age range;
- You have a salary increase after January 1;
- You change union affiliation; or
- You return from an approved leave.

How to File a Claim

Upon your death, your designated beneficiary(ies) should contact The Hartford within 30 days to file a claim. Your beneficiary can contact The Hartford at 1-888-563-1124.

For More Information

To learn more about your Optional Life and Optional Life and Accidental Death & Dismemberment Plans, go to www.TheHartford.com/mybenefits or call 1-888-563-1124.

Optional Dependent Life Insurance

If you have eligible dependents covered under the Basic Dependent Life Insurance plan, you may choose to purchase additional coverage for them under the Optional Dependent Life Insurance plan at competitive group rates.

The Optional Dependent Life Insurance plan provides your eligible dependent(s) with life insurance coverage in addition to that coverage paid under the Basic Dependent Life Insurance plan that would be paid to you in the event of his/her death.

You should not have duplicate coverage for your spouse or dependents. Two spouses cannot cover the other for voluntary life insurance. Only one parent/employee should cover the dependents for voluntary dependent life. You cannot cover a benefit-eligible dependent who is also an employee.

If you elect Optional Dependent Life Insurance, your dependents' coverage generally begins the first of the month following your date of hire, if you and all of these conditions are met:

- The person is your qualified dependent;
- You are eligible for Basic Dependent Life Insurance coverage;
- You are covered under the Basic Life Insurance plan; and
- The plan has not been discontinued.

Coverage Amounts

You may choose additional coverage for your eligible dependents as follows:

- Your spouse: up to \$100,000, in increments of \$10,000
- Your children: \$10,000

Note: Dependent Life Insurance amounts are based on Basic Dependent Life Insurance and Optional Dependent Life Insurance amounts combined.

Evidence of Insurability (EOI)

You must provide Evidence of Insurability (EOI) for any amounts over \$30,000 for your spouse's coverage. EOI is not required for your dependent child's coverage or for your spouse's coverage equal to \$10,000. However, if you do not enroll in coverage when first eligible, you must provide EOI regardless of coverage amount.

Cost of Coverage

The cost of coverage for your dependent children is \$.49 per pay for 21-pay employees and \$.39 per pay for 26-pay employees. The cost of coverage for your spouse is based on your spouse's age, as follows:

Your Spouse's Age	Optional Dependent Life Insurance Rate per Thousand
Under 25	\$0.042
25 - 29	\$0.051
30 – 34	\$0.055
35 – 39	\$0.072
40 – 44	\$0.096
45 – 49	\$0.145
50 – 54	\$0.215
55 – 59	\$0.360
60 – 64	\$0.713
65 – 69	\$1.272
70 – 74	\$2.363
75 and up	\$3.854

Qualified Dependents

Your dependents are eligible for the Optional Dependent Life Insurance plan while you are eligible for the Basic Life and Accidental Death and Dismemberment plan and if they are considered to be a qualified dependent under the plan. Your qualified dependents include:

- Your spouse; and
- Your unmarried children, stepchildren, legally adopted children, or any other children related to you by blood or marriage who are age 26 or younger or age 26 or older and disabled, and:
 - Live with you in a regular parent-child relationship; and/or
 - You claimed as a dependent on your last filed federal income tax return provided such children are primarily dependent upon you for financial support and maintenance.

A child can only be considered the qualified dependent of one City Schools employee.

Beneficiary

You are automatically the beneficiary for your qualified dependent's Optional Dependent Life Insurance plan.

How to File a Claim

Upon your dependent's death, you should contact The Hartford within 30 days to file a claim. You can contact The Hartford at 1-888-563-1124.

For More Information

To learn more about your Optional Dependent Life Insurance Plan, go to www.TheHartford.com/mybenefits or call 1-888-563-1124.

Benefit Amount for Accidental Death and Dismemberment Plans

If you sustain an injury or death due to an accident, you or in the event of your death, your beneficiary, will receive a percentage of your benefit amount as shown below.

For Loss of:	Percentage of Benefit Amount:
Life	100%
Both hands or both feet or sight of both eyes	100%
One hand and one foot	100%
Speech and hearing in both ears	100%
Either hand or foot and sight of one eye	100%
Movement of both upper and lower limbs (quadriplegia)	100%
Movement of both lower limbs (paraplegia)	75%
Movement of three limbs (triplegia)	75%
Movement of the upper and lower limbs of one side of the body (hemiplegia)	50%
Either hand or foot	50%
Sight of one eye	50%
Movement of one limb (uniplegia)	25%
Thumb and index finger of either hand	25%

Loss means with regard to:

- Hands and feet, actual severance through or above wrist or ankle joints;
- Sight, speech and hearing, entire and irrecoverable loss thereof;
- Thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
- Movement, complete and irreversible paralysis of such limbs.

What is Not Covered

The Life and AD&D insurance plans through The Hartford do not cover any loss caused or contributed to by:

- Intentionally self-inflicted Injury;
- Suicide or attempted suicide, whether sane or insane;
- War or act of war, whether declared or not;
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
- Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
- Injury sustained while committing or attempting to commit a felony; or
- Injury sustained while Intoxicated.

The Hartford Life and AD&D Plan Definitions

Active Employee means an employee who works for the City Schools on a regular basis in the usual course of the City Schools' business. This must be at least the number of hours shown in the schedule of insurance.

Actively at Work means at work with your employer on a day that is one of your employer's scheduled workdays. On that day, you must be performing for wage or profit all of the regular duties of your job:

- In the usual way; and
- For your usual number of hours.

The Hartford will also consider you to be actively at work on any regularly scheduled vacation day or holiday, only if you were actively at work on the preceding scheduled work day.

Common Carrier means a conveyance operated by a concern, other than the policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern.

Contributory Coverage means coverage for which you are required to contribute toward the cost. Contributory coverage is shown in the schedule of insurance.

Dependent Child(ren) means:

Your unmarried children, stepchildren, legally adopted children, or any other children related to you by blood or marriage who are age 26 or younger or age 26 or older and disabled, and:

- Live with you in a regular parent-child relationship; and/or
- You claimed as a dependent on your last filed federal income tax return provided such children are primarily dependent upon you for financial support and maintenance.

Dependents means your spouse and your dependent child(ren). A dependent must be a citizen or legal resident of the United States, its territories and protectorates. Any person who is in full-time military service cannot be a dependent.

Earnings means your regular annual rate of pay, not counting bonuses, commissions and tips and tokens, overtime pay, or any other fringe benefits or extra compensation, in effect on January 1.

However, if you are an hourly paid employee, earnings means the product of:

- The average number of hours you worked per year, not including overtime, over the most recent 1 year period immediately prior to January 1, multiplied by your hourly wage in effect on the date immediately prior to January 1.

Employer means the policyholder.

Guaranteed Issue Amount means the amount of life insurance for which The Hartford does not require evidence of insurability. The guaranteed issue amount is shown in the schedule of insurance.

Injury means bodily injury resulting:

- directly from an accident; and
- independently of all other causes;

which occurs while you are covered under the policy.

Loss resulting from:

- sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
- medical or surgical treatment of a sickness or disease;

is not considered as resulting from injury.

Motor Vehicle means a self-propelled, four or more wheeled:

- private passenger: car, station wagon, van, or sport utility vehicle;
- motor home or camper; or
- pick-up truck;

not being used as a common carrier.

A motor vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers, or any other type of equipment vehicles.

Non-Contributory Coverage means coverage for which you are not required to contribute toward the cost. Non-contributory coverage is shown in the schedule of insurance.

Normal Retirement Age means the Social Security normal retirement age under the most recent amendments to the United States Social Security Act. It is determined by your date of birth, as follows:

Year of Birth	Normal Retirement Age	Year of Birth	Normal Retirement Age
1937 or before	65	1955	66 + 2 months
1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months
1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

Physician means a person who is:

- A doctor of medicine, osteopathy, psychology, or other legally qualified practitioner of a healing art that The Hartford recognizes or is required by law to recognize;
- Licensed to practice in the jurisdiction where care is being given;
- Practicing within the scope of that license; and
- Not related to you by blood or marriage.

Prior Policy means the group life insurance policy carried by your policyholder on the day before the Policy effective date and will only include the coverage which is transferred to The Hartford.

Related means your spouse, or other adult living with you, or your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Your Disability Benefits

Disability income insurance provides financial security to help protect you and your family by replacing a portion of your income in the event you become sick, hurt, or unable to work for an extended period of time. You have two Long Term Disability (LTD) insurance options that are administered through The Hartford:

- Plan A: 180-day waiting period before benefits are paid; or
- Plan B: 90-day waiting period before benefits are paid.

All full-time employees working 30 or more hours per week and all part-time employees working at least 17.5 hours per week are eligible to participate in the plan. Your coverage begins on the first day of the month following your date of hire if you enroll when you become eligible.

Proof of Good Health

If you enroll in Long Term Disability within the first 30 days of becoming eligible to enroll, you do not need to provide proof of good health, also known as evidence of insurability. If you do not enroll when you are first eligible but elect to enroll during a future open enrollment period, you may be asked to provide proof of good health. This may include, but is not limited to:

- A completed and signed application approved by The Hartford;
- A medical examination;
- An attending physician's statement; or
- Any additional information that The Hartford may require.

Coverage Amounts

Under either Plan A or Plan B, you can receive a monthly benefit equal to 60% of your pre-disability earnings, up to a maximum monthly benefit of \$7,500.

How the Plan Works

Benefits will begin once you have been continuously disabled for either 180 days (if you enrolled in Plan A) or 90 days (if you enrolled in Plan B). This period of time is known as the elimination period. You may be asked to submit proof of your disability before the plan pays benefits. How long you may continue to receive benefits will depend upon your age at the time you become disabled, as follows:

Age When Disabled	Benefits Payable
Before age 66	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

However, if your disability is related to mental illness, alcoholism, or substance abuse, benefits will be paid as follows:

- For as long as you are confined in a hospital or other facility licensed to provide medical care for the disabling condition; or
- If you are not confined, or after you are discharged and remain disabled, for a total of 24 months during your lifetime.

Recurring Disabilities

If you return to work after the elimination period and again become disabled due to the same or a related cause within six months of your return to work date, the recurrent disability will be considered as part of the original disability period. If you suffer a recurrent disability after six months of your return to work from a disability period, it will be considered a new disability for benefit purposes.

Coverage Costs

You pay the full cost for this coverage. Your monthly coverage rates will depend upon the plan you choose (A or B) and your age, as follows:

Long Term Disability Monthly Rates	Rate per Hundred	
	Plan A	Plan B
Under 25	\$0.040	\$0.075
25 – 29	\$0.044	\$0.079
30 – 34	\$0.054	\$0.107
35 – 39	\$0.076	\$0.131
40 – 44	\$0.130	\$0.190
45 – 49	\$0.201	\$0.272
50 – 54	\$0.279	\$0.371
55 – 59	\$0.411	\$0.524
60 – 64	\$0.663	\$0.752
65 – 69	\$1.086	\$1.027

Example

The following example illustrates how to calculate your bi-weekly Long Term Disability insurance amount. Suppose you are 34 years old and elect Plan B (90-day elimination period). Your salary is \$48,000 and your benefits are calculated based on 21 pay periods per year.

Calculation:	Amount:
Step 1: Compute your monthly salary (may not exceed \$12,500)	\$4,000.00
Step 2: Look up your rate based on your age	\$0.116
Step 3: Multiply monthly salary (\$4,000) by the rate (.116)	\$464.00
Step 4: Now divide that total by 100	\$4.64
Step 5: Annualize your monthly premium (multiply by 12)	\$55.68
Step 6: Divide the annual premium by 21 (pay periods)	\$2.65

When Benefits End

Your monthly disability benefit payment will end on the earliest of:

- The date you are no longer disabled;
- The date you fail to provide proof of loss;
- The date you are no longer under the regular care of a physician;
- The date you refuse The Hartford's request to submit to an examination by a physician or other qualified medical professional;
- The date of your death;
- The date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct, or limit the disabling condition;
- The last day benefits are payable according to the benefit schedule, shown earlier in this section;
- The date your current monthly earnings exceed:
 - 80% of your indexed pre-disability earnings if you are receiving benefits for being disabled from your occupation; or
 - The product of your indexed pre-disability earnings and the benefit percentage, if you are receiving benefits for being disabled from any occupation;
- The date that no further benefits are payable under any provision in the policy that limits benefit duration; or

- The date you refuse to participate in a rehabilitation program, or refuse to cooperate with or try the following, provided that a qualified physician or other qualified medical professional agrees that such modifications, rehabilitation program, or adaptive equipment accommodate your medical condition:
 - Modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the essential duties of your occupation;
 - Adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the essential duties of your occupation;
 - Modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the essential job duties of any occupation, if you were receiving benefits for being disabled from any occupation; or
 - Adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the essential duties of any occupation, if you were receiving benefits for being disabled from any occupation;

Waiver of Premium

If you become disabled and begin receiving disability benefits from this plan, you are not required to pay premiums for as long as benefits are payable.

What's Not Covered

The Hartford will not pay a benefit for any disability under this plan:

- Unless you are under the regular care of a physician,
- That is caused by or contributed to by war or act of war (declared or not);
- Caused by your commission of or attempt to commit a felony;
- Caused by or contributed to by your being engaged in an illegal occupation;
- Caused by or contributed to by an intentionally self-inflicted injury; or
- That results from or is caused or contributed to by a pre-existing condition unless at the time you become disabled:
 - You have not received medical care for the condition for 90 consecutive days while being covered under the plan; or
 - You have been continuously covered under the plan for 365 consecutive days or more.

How to File a Claim

You must file a claim in writing to The Hartford within 30 days after disability or loss occurs by completing a claim form, available online at www.baltimorecityschools.org.

Within 15 days of receiving your claim, The Hartford will send you additional forms to complete and submit proof of loss. You must submit proof of loss to The Hartford within 90 days.

Claim Appeal

If your claim for benefits is denied in whole or in part, you will receive written notification that will:

- Give the specific reason(s) for the denial;
- Make specific reference to the policy provision on which the denial is based;
- Provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
- Provide an explanation of the review procedure.

If your claim for benefits is denied, you have the right to appeal the claim. To do so, you:

- Must request a review upon written application within:
 - 180 days of receipt of claim denial if the claim requires The Hartford to make a determination of disability; or
 - 60 days of receipt of the claim denial if the claim does not require The Hartford to make a determination of disability; and
- May request copies of all documents, records, and other information relevant to your claim; and
- May submit written comments, documents, records and other information relating to your claim.

The Hartford will respond to you in writing with the final decision on the claim.

For More Information

To learn more about your disability benefits from The Hartford, contact The Hartford at:

- 1-888-563-1124, Monday through Friday, 8:00 a.m. to 8:00 p.m.
- www.TheHartford.com/mybenefits

Your Retirement Benefits

As an eligible Baltimore City Public School employee, you have several plans available to you to help you plan for your financial security in retirement:

- 403(b) Deferred Compensation Plan
- 457(b) Deferred Compensation Plan
- State Retirement and Pension System of Maryland (SRPS)
- Employees' Retirement System (ERS)

This section provides an overview of these plan options. This is a high-level summary of your benefits and does not include all details. If there is any discrepancy between this guide and the official plan documents, the official plan documents will govern.

About the Deferred Compensation Plan Options

The 403(b) and 457(b) Deferred Compensation Plans are retirement savings plans. They are administered by TSA Consulting Group, Inc. You may make contributions to the plans on a tax-deferred basis, and your contributions are invested. When you retire, you can withdraw your savings.

Who Is Eligible

Most employees are eligible to participate in both plans immediately upon employment; however, private contractors, appointed/elected trustees, school board members, and/or student workers are not eligible to participate in the 403(b) Plan.

Plan participants are permitted to make voluntary elective deferrals to both plans.

Contributions

Your contribution limits for the plans are as follows:

	457(b) Plan	403(b) Plan
2026 Contribution Limit	\$24,500	\$24,500
Coordination of Contribution Limits	Contribution limit not reduced by any other plans	Contribution limit reduced by any elective deferrals made to 401(k) plans, SEP plans, or SIMPLE plans
2026 Catch-Up Contribution Limit , for individuals who will be age 50 or older in 2026	Ages 50 – 59 and 64+: \$8,000 Ages 60 – 63: \$11,500	Ages 50 – 59 and 64+: \$8,000 Ages 60 – 63: \$11,500

Service-Based Catch-Up Amount

The 403(b) special catch-up provision allows participants to make additional contributions of up to \$3,000 to the 403(b) account if, as of the preceding calendar year, the participant has completed 15 or more full years of employment with the current employer, not averaged over \$5,000 per year in annual contributions, and has not utilized catch-up contributions in excess of the aggregate of \$15,000. For more information about this provision, visit <https://www.tsacg.com>.

Enrolling in the Plan

If you wish to enroll in the 403(b) and/or 457(b) plan, you must first select a provider and investment product that best suits your needs. Contact the provider directly to set up your account. Once your account is established with your selected provider, complete the online Salary Reduction Agreement (SRA) process accessible on the Baltimore City Public Schools' page on TSA Consulting Group's website via the following link: <https://www.tsacg.com/individual/plan-sponsor/maryland/baltimore-city-public-schools/>. By completing this online SRA process, you authorize Baltimore City Public Schools to withhold 403(b) and/or 457(b) contributions from your pay, and send those funds to the investment provider on your behalf.

Changing or Stopping Contributions

Baltimore City Public Schools has gone paperless, so if you wish to start, stop, or modify your contributions, you must complete the online SRA process available on the website via the following link: <https://www.tsacg.com/individual/plan-sponsor/maryland/baltimore-city-public-schools/>. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

Vesting

You are fully vested in your contributions and any earnings at all times.

Distributions

Distributions may be made from the plans including loans, transfers, rollovers, exchanges, hardship withdrawals, and distributions at retirement.

Loans

You may be eligible to borrow from your 403(b) and/or 457(b) plan accounts up to the lesser of:

- \$50,000; or
- One half of the vested benefits (or \$10,000, if greater).

Loans are generally granted for a term of five years or less or more if taken to purchase a principal residence. You must repay your loans through monthly payments as directed by the provider. If you are thinking of taking a loan, you should consult a tax advisor.

Transfers

A plan-to-plan transfer is defined as the movement of a 403(b) or 457(b) account from a previous plan sponsor's plan and retaining the same account with the authorized investment provider under the new plan sponsor's plan.

Rollovers

If you leave Baltimore City Public Schools, you are permitted to rollover your 403(b) and/or 457(b) accounts to the following plan types:

- 457(b) governmental plan
- 403(b) plan
- IRA (traditional or SEP)
- 401(a) plan (pension, profit sharing, 401(k), STRS)

Exchanges

Within each plan, you may exchange account accumulations from one investment provider to another investment provider that is authorized under the same plan. Exchanges can only be made from a 457(b) plan to a 457(b) plan or from a 403(b) plan to a 403(b) plan.

Hardship Withdrawals

You may request a hardship withdrawal from your account in the event of an unforeseeable emergency (sudden and unforeseen) beyond your control as follows.

457(b) Plan	403(b) Plan
• Medical Care • Casualty Loss	• Medical Care • Payments needed to prevent eviction from or foreclosure on home • Payment of tuition • Purchase of a home

Distributions at Retirement

Retirement plan distributions are restricted by IRS regulations. You may not take a distribution of 403(b) plan accumulations without penalty unless you have reached age 59 ½ or are separated from service in the year you turn 55 or older.

Generally, a distribution cannot be made from a 457(b) account until you have a severance from employment, reach age 70 ½, or are deceased.

Plan Definitions

403(b) Deferred Compensation Plan

Account means the account or accumulation maintained for the benefit of any participant or beneficiary under an annuity contract or a custodial account.

Account Balance means the value of the aggregate amount credited to each participant's account under all accounts including the participant's elective deferrals, the earnings or loss of each annuity contract or a custodial account (net of expenses) allocable to the participant, any transfers for the participant's benefit, and any distribution made to the participant or the participant's beneficiary. If a Participant has more than one beneficiary at the time of the participant's death, then a separate account balance shall be maintained for each beneficiary. The account balance includes any account established under the plan for rollover contributions and plan-to-plan transfers made for a participant if such contributions are authorized under the adoption agreement, the account established for a beneficiary after a participant's death, and any account or accounts established for an alternate payee.

Administrator means TSA Consulting Group, Inc. Notwithstanding this appointment, the employer may delegate, by separate agreement, any administrative responsibilities hereunder to one or more persons, committees, vendor, or other organization.

Annuity Contract means a nontransferable contract as defined in section 403(b)(1) of the Code, established for each participant by the employer, or by each participant individually, that is issued by an insurance company qualified to issue annuities in the state in which the employer or participant, as applicable, resides and that includes payment in the form of an annuity.

Beneficiary means the designated person who is entitled to receive benefits under the plan after the death of a participant subject to such additional rules as may be set forth in the individual agreements.

Custodial Account means the group or individual custodial account or accounts, as defined in section 403(b)(7) of the Code, established for each participant by the employer, or by each participant individually, to hold assets of the plan.

Code means the Internal Revenue Code of 1986 as now in effect or as hereafter amended. All citations to sections of the Code are to such sections as they may from time to time be amended or renumbered.

Compensation means all cash compensation for services to the employer including salary, wages, fees, commissions, bonuses, and overtime pay that is includible in the employee's gross income for the calendar year, plus amounts that would be cash compensation for services to the employer includible in the employee's gross income for the calendar year but for a compensation reduction election under section 125, 132(f), 401(k), 403(b), or 457(b) of the Code (including an election made to reduce compensation in order to have elective deferrals under the plan).

Disabled means the definition of disability provided in the applicable Individual agreement.

Elective Deferral means the employer contributions made to the plan at the election of the participant in lieu of receiving cash compensation. Elective deferrals are limited to pre-tax salary reduction contributions unless the employer has authorized Roth 403(b) contributions on the adoption agreement that conform to the requirements of the plan policy.

Employee means each individual, whether appointed or elected, who is a common law employee of the employer performing services for a public school as an employee of the employer. This definition is not applicable unless the employee's compensation for performing services for a public school is paid by the employer. Further, a person occupying an elective or appointive public office is not an employee performing services for a public school unless such office is one to which an individual is elected or appointed only if the individual has received training, or is experienced in the field of education. A public office includes any elective or appointive office of a state or local government.

Employer means the public education organization identified in the adoption agreement as the employer.

Employer Contributions means any non-elective contributions made to the plan by the employer as provided in the adoption agreement.

Funding Vehicles means the annuity contracts or custodial accounts issued for funding amounts held under the plan and authorized by the employer for use under the plan.

Includible Compensation means an employee's actual wages in box 1 of Form W-2 for a year for services to the Employer, but subject to a maximum of \$245,000 (or such higher maximum as may apply under section 401(a)(17) of the Code) and increased (up to the dollar maximum) by any compensation reduction election under section 125, 132(f), 401(k), 403(b), or 457(b) of the Code (including any elective deferral under the plan). The amount of includible compensation is determined without regard to any community property laws. Beginning in 2009 and thereafter such term also includes any "differential pay" that may be received from the employer while performing qualified military service under section 414(u) of the Code.

Individual Agreement means an agreement between a vendor and the employer or a vendor and a participant that constitutes or governs a custodial account or an annuity contract.

Participant means an individual for whom elective deferrals or other contributions permitted under the plan are currently being made or for whom such contributions have previously been made under the plan, and who has not received a distribution of his or her entire benefit under the plan.

Plan means the name given to this plan by the employer in the adoption agreement and may include separate documents that govern special provisions if so indicated in the adoption agreement.

Plan Year means the calendar year.

Related Employer means the employer and any other entity which is under common control with the employer under section 414(b) or (c) of the Code. For this purpose, the employer shall determine which entities are related employers based on a reasonable, good faith standard and taking into account the special rules applicable under Notice 89-23, 1989-1 C.B. 654.

Roth 403(b) Contribution means, if authorized in the adoption agreement, any contribution made by a participant which is designated as a Roth 403(b) contribution in accordance with Section 10 of the plan that qualifies as a Roth 403(b) contribution under section 402A of the Code.

Severance from Employment means severance from employment with the employer and any related entity. However, a severance from employment also occurs on any date on which an employee ceases to be an employee of a public school, even though the employee may continue to be employed by a related employer that is another unit of the State or local government that is not a public school or in a capacity that is not employment with a public school (e.g., ceasing to be an employee performing services for a public school but continuing to work for the same State or local government employer).

Vendor means the provider of an annuity contract or custodial account, or any organization acting on their behalf under this plan.

Valuation Date means each business day of the plan year.

457(b) Deferred Compensation Plan

Account means the separate account or accounts established and maintained by the trustee for each participant under the terms of the plan. 457(b) rollover account means that portion of a participant's account attributable to rollover contributions received from another eligible 457(b) deferred compensation plan sponsored by a governmental employer.

Administrator means employer or the alternate administrator appointed under section 6.2 of the plan to act as such under this plan.

Adoption Agreement means the separate agreement as executed by employer and which sets forth the elective provisions of the plan. The Adoption Agreement shall be included as part of the plan.

Beneficiary means the person(s), trust(s), or other entities designated by the participant to receive the balance of the participant's accounts, if any, upon the participant's death. Elections made by a participant hereunder shall be binding on any such beneficiary(ies).

Code means the Internal Revenue Code of 1986 as amended, and any regulations issued thereunder.

Contribution means all contributions made hereunder by or for the benefit of each participant and deposited into each participant's account. A rollover contribution means a contribution of an eligible rollover distribution made by a participant from another eligible deferred compensation 457(b) plan sponsored by a governmental employer.

Eligible Individual means any individual who qualifies for eligibility in accordance with the applicable provisions of the adoption agreement and under section 2.1 of the plan. Individuals who do not perform services for employer may not defer compensation under the plan.

Employee means any individual in the employ of the employer who is designated on the payroll records of the employer as a common law employee. Even if a subsequent determination by a court of competent jurisdiction or governmental agency reclassifies any individual as a common law employee, such individual shall be excluded from “Employee” status hereunder. “Leased employees” described in Code Section 414(n) of the Code shall not be included as employees hereunder.

Employer means the governmental organization identified as employer in the adoption agreement, any successor thereto that elects to maintain this plan, and any predecessor which has maintained this plan.

Governmental Employer means any entity described in Section 457(e) (1) (A) of the Code. **1.11 Includible compensation** means the remuneration paid by employer to an eligible individual that qualifies as “includible compensation” under Section 457(e) (5) of the Code. Beginning in 2009 and thereafter, such term also includes any “differential pay” that may be received from the employer while performing qualified military service under Code Section 414(u).

Independent Contractor means any person receiving cash remuneration from the employer for services rendered to employer pursuant to one or more contracts, if such person is not an employee.

Investment Product means any investment product specifically approved and authorized by employer to be offered to participants under the plan, provided that such products are held in an annuity contract, custodial account or trust that qualifies as a trust to hold 457(b) plan assets under Section 401(f) of the Code.

Participant means any eligible individual who has executed a participation agreement and has not become ineligible to participate in the plan, and any employee for whom the employer has made a direct contribution to the plan. An “active participant” is any participant who is currently deferring compensation under a participation agreement, or who is receiving direct employer contributions to his account. An “inactive participant” is any former participant who is not currently deferring compensation hereunder, or who is not receiving direct employer contributions to his account.

Participation Agreement means an agreement by which an eligible individual agrees to defer current remuneration otherwise payable from the employer into the plan and the employer agrees to deposit such deferred amount into the plan in accordance with the terms of the agreement.

Plan means this 457(b) Deferred Compensation Plan for governmental employers and the related adoption agreement as executed by the employer along with any custodial account, trust, or annuity contract as may be established or maintained by a provider of investment products available hereunder.

Trust means any trust established under applicable state law by the employer to hold participant accounts hereunder as provided in Article IV, and any other account, contract or instrument that qualifies as a trust under the terms of Section 401(f) of the Code.

Trustee means the person, entity or organization, if any, designated to act as trustee of the plan in the adoption agreement. If the assets of the plan are held in annuity contracts and/or custodial accounts, then the issuer of such annuity contracts and/or custodial accounts must qualify under Sections 457(g) and 401(f) of the Code. The term “trustee” shall include an insurer issuing such annuity contracts and/or the issuer of such custodial accounts.

Authorized Investment Providers

Listed below are the names of the current authorized tax shelter companies. Please review the list provided online at <https://www.tsacg.com/individual/plan-sponsor/maryland/baltimore-city-public-schools/> for the most up-to-date list of Authorized Investment Providers.

403(b) Plan	457(b) Plan
• American Century Services, LLC • AXA Equitable Life Insurance Company • Lincoln Investment Planning, Inc. • Lincoln National Life Insurance Company • MetLife & Annuity Company of Connecticut • MetLife Investors • MetLife Resources • New York Life Insurance & Annuity Corp. • PlanMember Services • VALIC • VOYA Financial	• American Century Services, LLC • American General Life Companies • AXA Equitable Life Insurance Company • Lincoln Investment Planning, Inc. • Lincoln National Life Insurance Company • Metropolitan Life Insurance Company • New York Life Insurance & Annuity Corp. • PlanMember Services • VALIC • VOYA Financial

For more information

If you have questions about the 403(b) Deferred Compensation Plan or the 457(b) Deferred Compensation Plan, contact TSA Consulting Group at 1-888-796-3786 or visit <https://www.tsacg.com>.

State Retirement and Pension System

There are several plans that make up the State Retirement and Pension System. This section is a brief overview of the Reformed, Contributory, and Non-Contributory Pension Systems for Employees and Teachers of the State of Maryland. For more information and more details on the State Retirement and Pension System, please visit <http://www.sra.state.md.us/>.

Who Can Participate

Membership in the Employees' and Teachers' Pension System is automatic for permanent employees or teachers who work at least 500 hours in the first fiscal year of employment.

Your Contributions

You must contribute the following:

- 7% of your earnable compensation if you participate in either the Reformed or Alternate Contributory Pension System;
- 2% of your earnable compensation if you participate in the Contributory Pension System; or
- 5% of any portion of your earnable compensation that exceeds the Social Security Wage Base if you participate in the Non-Contributory Pension System.

Vesting

Vesting is your right to receive benefits under the Pension System. You become vested in the Reformed Contributory Pension benefit after you have accrued at least 10 years of eligibility service. All other members are vested after five years of eligibility service.

For More Information

To learn more about the plan, call 410-625-5555 or go to <http://www.sra.state.md.us/>.

Employees' Retirement System of Baltimore

The Employees' Retirement System (ERS) is a defined benefit retirement plan established by the City of Baltimore in 1926. This section is a brief overview of the plan. For more information and more details on the Employees' Retirement System, please visit <http://www.bcercs.org>.

Who Can Participate

ERS covers regular and permanent officers, agents, and employees of the City of Baltimore. The date you became a plan member determines your class under the plan as follows:

- **Class A:** If you were hired before July 1, 1979 and became a member on or after January 1, 1954, you are considered a Class A contributory member.
- **Class B:** If you were a member of the plan on January 1, 1954 and did not elect Class A membership, you are considered a Class B contributory member.
- **Class C:** If you were hired after July 1, 1979, you are automatically a non-contributory (Class C) member of the plan on the first anniversary of your full-time employment. The majority of plan participants are non-contributory.

Contributions

Class C members do not contribute to the plan. Class A and B members contribute 4% of earnable compensation.

When You Can Receive Benefits

Class C participants are eligible to receive benefits from this plan after 30 years of normal service (regardless of your age); or, when you reach age 65 and have at least five years of membership service; or, when you reach age 55 and have at least five years of membership service (this is considered early retirement).

For More Information

To learn more about the plan, call 410-984-3200 or go to <http://www.bcercs.org>.

Retirement Savings Plan

The Retirement Savings Plan (RSP) is a defined benefit retirement plan established by the City of Baltimore for eligible employees hired July 1, 2014 and after. This section is a brief overview of the plan.

Who Can Participate

You are eligible to participate in the Employees' Retirement Systems (ERS) if you are newly hired or rehired after July 1, 2014 by the City of Baltimore or the Baltimore City Public Schools (BCPS). ERS participation is only available for those BCPS employees not eligible for participation in the State of Maryland Retirement and Pension System.

Contributions

You can contribute 5% to the plan. Matching by the City Schools depends on the plan elected.

When You Can Receive Benefits

401(a) Defined Contribution Plan-

- **Hybrid:** You become 100% vested: after 5 years of eligible vesting service. If you reach normal retirement age (age 65) and are still employed, or upon disability or death.
- **Non-Hybrid:** You are always 100% vested in the portion of your 401(a) account balance attributable to your own contributions and gains or losses on those contributions. You become 100% vested in the portion of your 401(a) account balance attributable to employer contributions and gains or losses on those contributions:
 - After 5 years of eligible vesting service, if you reach normal retirement age (age 65) and are still employed
 - Upon disability or death

457(b) Deferred Compensation Plan

You are always 100% vested.

For More Information

For assistance, contact your Nationwide Retirement Specialist at (855) 826-5407 Monday – Friday 8 a.m. – 11 p.m. ET or Saturday 9 a.m. – 6 p.m. ET. Local walk-in office hours located at 7 E. Redwood Street, 11th Floor Baltimore, MD 21202 on Monday – Friday 8 a.m. – 4:30 p.m. You can also call (443) 984-2389.

Enrolling for Retiree Health Benefits

To continue your health benefits during retirement, you must re-enroll online using the City of Baltimore's enrollment system. To be eligible for retiree health benefits when you retire, you must receive a retirement check. You will receive a benefits package with enrollment instructions after your first electronic retirement check has been deposited. For more information, contact the City of Baltimore's Human Capital Office at 410-396-8885.

Enrollment is not automatic. You must enroll in the retiree health benefits program.

Remember, if you or your eligible dependents are Medicare eligible due to age, end stage renal disease (ESRD), or certain medical disabilities, you or your eligible dependents must enroll in Medicare Part A (hospitalization) and Part B (medical) to participate in a retiree health plan.

Continued Benefits for Your Survivors

In order for a dependent to continue eligibility for retiree health benefits upon the death of the retiree, the dependent(s) must receive a monthly retirement check. Those not receiving retirement checks may be eligible for COBRA benefits, described later in this guide.

How to Coordinate with Medicare (TEFRA)

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), passed by Congress, was designed to refund federal expenditures and lower the federal deficit.

TEFRA requires that Medicare become the secondary health carrier for active employees who are age 65 or older. Your private carrier is your primary health care provider. Therefore, three months before you or your spouse reach age 65, contact the Department of Employee Services for enrollment instructions. You must complete another Benefit Selection Form for the same coverage, marking the word TEFRA across the top of the form. You should follow this procedure when you reach age 65, and again when your spouse reaches age 65, or vice versa.

Medicare Part A

You should also apply for Part A Medicare coverage at any Social Security Office three months before your 65th birthday, even if you are covered under one of the health plans offered by the City Schools. Part A will supplement your employer's coverage at no cost to you.

Medicare Part B

For active employees and their dependents age 65 or over, Medicare medical insurance (Part B) is voluntary. You are not required to enroll in Medicare Part B. However, you must apply for Part B before retiring and applying for benefits as a retiree.

If you elect not to take Part B as an active employee, when you retire, you will not have to pay the 10% penalty imposed by Medicare. You will, however, need to provide Medicare with a letter confirming that you were continuously enrolled in a health plan from age 65 to your retirement date. Contact the Department of Employee Services for this letter.

If You Are Not Enrolled in a Health Plan

If you are not enrolled in an employee health plan and you are eligible for Medicare, you may need to apply for Medicare Parts A and B. If you do not have Part B and do not have active health insurance, special rules and penalties may apply, such as paying a 10% higher premium if you don't enroll when first eligible. Contact Social Security before becoming Medicare eligible.

Medicare Secondary Payor (MSP) Reporting

Under rules for Medicare Secondary Payer (MSP) Mandatory Reporting, the federal law requires the collection and reporting through employer group health benefit plans of Social Security numbers for all covered participants, including employees, retirees, and their dependents. Noncompliance may result in loss of coverage for covered participants with invalid or missing Social Security numbers.

Contact Information

Have questions about your benefits? Contact the City Schools' benefits providers directly or email the Department of Employee Services at benefits@bcps.k12.md.us. You may also contact us at 410-396-8885, Monday through Friday, 8 a.m. to 5 p.m.

Benefit Provider	Phone Number	Website
Medical		
CareFirst BlueCross BlueShield (PPN, BlueChoice POS, Major Medical)	410-581-3506, 1-800- 648-5285 (Monday-Friday, 8:00 a.m. to 9:00 p.m.)	www.carefirst.com
Kaiser Permanente	301-468-6000, 1-800- 777-7902 (Monday-Friday, 7:30 a.m. to 5:30 p.m.)	www.kp.org
Prescription Drug		
Express Scripts	1-877-206-7430 (24/7)	www.express-scripts.com
Dental		
CareFirst BlueCross BlueShield (DPPO, DHMO)	1-866-891-2802 (Monday-Friday, 8:30 a.m. to 5:00 p.m.)	www.carefirst.com
Vision		
National Vision Administrators (Basic, Buy-Up)	1-800-672-7723 (24/7)	www.e-nva.com
Employee Assistance Program (EAP)		
ComPsych GuidanceResources	1-855-388-4255 (24/7)	guidanceresources.com (Web ID: CitySchools)
Flexible Spending Accounts		
P&A (Medical Care FSA, Dependent Care FSA)	1-800-688-2611 (Monday-Friday, 8:30 a.m. to 10:00 p.m.)	www.padmin.com
Life and Accidental Death and Dismemberment (AD&D)		
The Hartford (Basic Life and AD&D, Supplemental Life and AD&D, Spousal Life, Child Life)	1-888-563-1124 (Monday-Friday, 8:00 a.m. to 8:00 p.m.)	www.TheHartford.com/mybenefits
Disability		
The Hartford	1-888-563-1124 (Monday-Friday, 8:00 a.m. to 8:00 p.m.)	www.TheHartford.com/mybenefits
Retirement		

TSA Consulting Group (403(b), 457(b))	1-888-796-3786 (Monday-Friday, 8:00 a.m. to 8:00 p.m.)	https://www.tsacg.com
State Retirement and Pension System of Maryland (SRPS)	410-625-5555, 1-800-492-5909 (Monday-Friday, 8:30 a.m. to 4:30 p.m.)	http://www.sra.state.md.us
Employees' Retirement System of Baltimore (ERS)	443-984-3200, 1-877-273-7136 (Monday-Friday, 8:30 a.m. to 4:30 p.m.)	http://www.bcercs.org
Retirement Savings Plan (RSP)	443-984-2389 (Monday – Friday, 8 a.m. to 4:30 p.m.) 1-855-826-5407 (Monday through Friday 8 a.m. to 11 p.m.)	www.retirewithbmore.com
COBRA		
P&A (COBRA)	1-800-688-2611 (Monday-Friday, 8:30 a.m. to 10:00 p.m.)	www.padmin.com

Continuation of Coverage for You and Your Dependents (COBRA)

About COBRA Continuation

A federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers sponsoring group health plans to offer employees and their families the opportunity to temporarily extend their health coverage (continuation coverage) at group rates in certain instances (COBRA Qualifying Events) when coverage under the plan would otherwise end. This notice summarizes your rights and obligations under the continuation of coverage provisions of the law. But you and your spouse should take the time to read this notice carefully.

COBRA continuation coverage is administered by:

P&A
17 Court Street Suite 500
Buffalo, NY 14202
Phone: 1-800-688-2611

COBRA Continuation Coverage

If you choose continuation coverage, City Schools will provide you with the same coverage provided to active employees and their family members under its health plans (including HMOs) and/or dental plans. This means that if the coverage for active employees and their family members is modified, your continuation coverage will also be modified. You may only continue coverage (including options for that coverage) you had at the time COBRA rights began, not add coverage. If no coverage existed immediately prior to the qualifying events listed next, no COBRA continuation coverage is available. Continuation of coverage must be elected within the election period.

COBRA Qualifying Events

If you are a City Schools employee and are covered by one of its health plans (including HMOs) and/or the dental plans, you have the right to choose continuation of this coverage if you or your eligible dependents loses your coverage as a result of the following qualifying events:

- Your death;
- Termination of your employment for any reason other than your gross misconduct;
- Your hours are reduced;
- Change in your employment status which causes you to no longer be eligible for benefits;
- Your legal separation or divorce;
- Your entitlement to Medicare; or
- End of eligibility status under the plan (i.e., the end of the month in which a child turns age 26 and is no longer a full-time student).

Your Responsibility Under COBRA

You, your spouse, or child must notify City Schools in writing within 60 days after a divorce or legal separation or a child's loss of eligibility status under the health plans (including HMOs) and/or the dental, prescription drug, or vision plans (or, if later, 60 days from the date coverage would terminate). City Schools will notify P&A, the plan administrator. If you fail to provide the notice within the 60-day period, your spouse's or child's coverage will cease at the end of the month in which the divorce or legal separation or the child's loss of eligibility status occurs and cannot be continued under COBRA.

In addition, if you have a newborn child or if you adopt a child or have a child placed with you for adoption while you are covered under COBRA, your child will be eligible for COBRA continuation coverage if you notify City Schools of the birth or adoption within 60 days.

If you or a covered dependent is determined by the Social Security Administration to be disabled at the time of the COBRA qualifying event or during the 60-day period following the COBRA qualifying event, you or a family member must notify P&A. This notification must be made within 60 days of the Social Security Administration's determination of disability and before the end of the original 18-month continuation coverage period.

City Schools' Responsibility Under COBRA

City Schools must notify P&A of any employment-related qualifying event within 30 days of the event (or from the date coverage is lost). P&A must notify you and your qualified dependents in writing of your rights to COBRA continuation coverage within 14 days from the date P&A is notified of a qualifying event by you, your qualified dependents, or City Schools.

Length of Continuation Coverage

You and your qualified dependents may individually elect to continue the benefits in force prior to the event for up to 18 months, if group coverage ends because:

- Your employment is terminated (voluntarily or involuntarily, except if you are fired for gross misconduct); or
- Your hours are reduced so that you are no longer eligible for the group plan.

Your spouse and/or dependent children may extend or individually elect the benefits in force at the time of the event up to 36 months if coverage ends due to a second qualifying event, as listed below:

- Death;
- Divorce;
- Legal separation; or
- Subsequent entitlement to Medicare.

Your eligible dependent children may individually elect the benefits they had in force on the day of the event for up to 36 months if:

- They reach their 26th birthday and are not considered your eligible dependents; or
- They get married.

Benefits in force the day of the event may be continued under any one of these qualifying events without proof of good health.

Special Rules for Disabled Qualified Beneficiaries

You or any one of your eligible dependents may continue your COBRA coverage for up to 29 months from the date of the qualifying event if your group coverage ends because of one of the COBRA qualifying events listed above and:

- You are considered disabled by the Social Security Administration at the time of the COBRA qualifying event; or
- You become disabled (as determined by the Social Security Administration) during the first 60 days of your COBRA coverage.

When you (or a dependent) receive notice from the Social Security Administration verifying that you are eligible for Social Security disability benefits, you must notify P&A within 60 days of the determination and within 18 months of the original qualifying event.

If you (or a dependent) are receiving Social Security Administration disability benefits because you became disabled during the first 60 days of your COBRA coverage, and the Social Security Administration subsequently determines that you are no longer disabled, you must notify City Schools within 30 days of the Social Security Administration's final determination.

How to Elect COBRA

When City Schools receives your timely written notice of your divorce or legal separation or your child's loss of eligibility status, City Schools will notify P&A and P&A will send you or your eligible dependent information on how to elect COBRA continuation coverage.

If you, your spouse, and/or your children will lose coverage because of the following, P&A will automatically send you or your eligible dependent information on how to elect COBRA continuation coverage:

- Termination of your employment;
- Reduction in your hours of employment;
- Your death; or
- Your entitlement to Medicare.

When you or your eligible dependent receive this information, read it carefully and respond within the time indicated in the notice.

To elect COBRA, you or your eligible dependent must complete and return the Election Form included in the notice and must pay the monthly premiums for COBRA continuation coverage specified in the notice. Each qualified beneficiary has 60 days from the date of the COBRA notice or the date coverage would terminate, whichever is later, to notify P&A of their decision to elect COBRA continuation coverage.

Individuals Eligible for Federal Trade Adjustment Assistance

Workers whose employment is adversely affected by international trade, such as increased imports or a shift in production to another country, may become eligible for federal Trade Adjustment Assistance (TAA). Part of this assistance is a 65% tax credit toward the purchase of COBRA coverage if loss of health coverage is trade-related.

To be eligible for the tax credit, you must currently be receiving or be eligible for trade adjustment assistance or considered an “eligible PBGC pension recipient;” paying premiums for qualified health insurance; not receiving other coverage; and not in prison. If you become eligible for TAA after a termination of employment or reduction of hours and did not elect COBRA coverage during your initial 60-day election period, you will be eligible for a second COBRA election period.

This second election period begins on the first day of the month in which you are determined to be a TAA-eligible individual, provided this second election is made within six months after the date health coverage was originally lost. If you elect COBRA coverage during this second election period, it is effective on the first day of the second election period and not on the date coverage originally was lost. However, the maximum COBRA coverage period is still measured from the date coverage was originally lost.

If You Fail to Elect COBRA

If you do not choose COBRA continuation coverage within the time allowed, your group medical and/or dental coverage will end at the time coverage would otherwise end.

The Cost of Continuation Coverage

Each individual who elects to continue coverage under COBRA must pay the full cost of coverage, plus 2% for administrative expenses. You pay for COBRA continuation coverage in monthly premiums that are due on the first day of each month. Payments not received within 30 days after your premium is due will result in loss of coverage retroactive to the day before your premium was due. Your first payment must be made within 45 days after you elect COBRA continuation coverage and is retroactive to the date you lost coverage.

An administrative fee equal to 50% of the full cost of coverage may be charged for COBRA continuation coverage for qualified disabled individuals beginning with the 19th month and continuing until COBRA coverage terminates. That means, for the first 18 months of COBRA coverage, you would pay 102% monthly, and for the remaining coverage period, you would pay 150% monthly. This includes a second (different) qualifying event, that would allow you up to 36 months of continuation coverage.

However, if a second qualifying event occurs within the original 18-month period of coverage, you cannot be charged more than 102% at any time during the 36-month period.

Loss of Continuation Coverage

There are certain circumstances that will cut short the period during which you and/or your dependents can have coverage continued under COBRA. These circumstances are:

- You, your spouse, or child fails to pay the monthly premium for the coverage within 30 days of its due date (or within 45 days, if it is the first monthly payment);
- You or your dependents become covered after the qualifying event under any other group health plan which has no exclusions or limitations regarding that person’s own pre-existing conditions (if any);
- You, your spouse, or your child becomes covered by Medicare after the qualifying event;
- City Schools ceases to provide any group health plan to its employees; or
- You extended coverage for up to 29 months due to your disability, and there has been a determination that you are no longer disabled.

Once COBRA coverage is cancelled, it will not be reinstated.

Proof of Insurability Not Required For COBRA

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all the costs for your continuation coverage. You will have a grace period of 30 days in which to pay the premium. The law also says that at the end of the 18-month or 36-month continuation coverage period, you must be allowed to enroll in any individual conversion health plan then provided under City Schools' health plans for employees, if available.

Important Notices

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA) of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Notice of Privacy Policy and Procedures

This notice is provided to you on behalf of:

- Baltimore City Public Schools Employee Health Care Plan (CareFirst);
- Baltimore City Public Schools Employee Health Care Plan (Kaiser);
- Baltimore City Public Schools Employee Prescription Drug Plan;
- Baltimore City Public Schools Employee Dental Care Plan;
- Baltimore City Public Schools Employee Dental Care Plan (PPO);
- Baltimore City Public Schools Employee Vision Care Plan; and
- Baltimore City Public Schools Employee Assistance Plan.

These plans comprise what is called an Affiliated Covered Entity and are treated as a single plan for purposes of this notice and the privacy rules that require it. For purposes of this notice, we will refer to these plans as a single "plan."

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered Protected Health Information, or PHI. The plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the plan may use or disclose your PHI. Except in specified circumstances, the plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (as your Human Capital representative, or contact the plan's Privacy Official, described below), and will be posted on any web site maintained by Baltimore City Public Schools that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosure, it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative, e.g. the person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the plan's uses and disclosures of your PHI.

Uses and Disclosures Related to Treatment, Payment, or Health Care Operations

- **Treatment:** Generally, and as you would expect, the plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident and it's important for your treatment team to know your blood type, the plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- **Payment:** Of course, the plan's most important function, as far as you are concerned, is that it pays for some or all of the medical care you receive (provided the care is covered by the plan). In the course of its payment operations, the plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the plan detailed information about the care they provided, so that they can be paid for their services. The plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this plan and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health care operations:** The plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages.

Other Uses and Disclosures of Your PHI Not Requiring Authorization

The law provides that the plan may use and disclose your PHI without authorization in the following circumstances:

- **To the plan sponsor:** The plan may disclose PHI to the employers (such as Baltimore City Public Schools) who sponsor or maintain the plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments; census, claim resolutions, and other matters related to plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to plan administration; finance department, for purposes of reconciling appropriate payments of premium to and benefits from the plan; and other matters related to plan administration; internal legal counsel, to assist with resolution of claim, coverage, and other disputes related to the plan's provision of benefits; School Board members and employee supervisors, where necessary, to approve certain leaves of absence (your authorization may be required in these latter cases before disclosure may be made).
- **Required by law:** The plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For public health activities:** The plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For health oversight activities:** The plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to decedents:** The plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the plan may disclose PHI to assist medical and psychiatric research.
- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions:** The plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization

For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the plan is required to have your written authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to Have an Opportunity to Object

The plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your Protected Health Information:

- **To request restrictions on uses and disclosures:** You have the right to ask that the plan limit how it uses or discloses your PHI. The plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The plan cannot agree to limit uses or disclosures that are required by law.
- **To choose how the plan contacts you:** You have the right to ask that the plan send you information at an alternative address or by an alternative means. The plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the plan or its vendors if you put your request in writing. The plan, or someone on behalf of the plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The plan or someone on its behalf will respond, normally within 60 days of receiving your request. The plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the plan or its vendor and/or not part of the plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices

If you think the plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Contact Person for Information or to Submit a Complaint

If you have questions about this notice please contact the plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the plan's privacy practices or handling of your PHI, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Zelda Johnson, Director – Employee Engagement, 410-396-8885

The plan's Deputy Privacy Official is:

Emily Nielson, Chief Human Capital Officer, 410-396-8885

Organized Health Care Arrangement Designation

The plan participates in what the federal privacy rules call an Organized Health Care Arrangement. The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the plan because it allows the insurers who participate in the Arrangement to share PHI with the plan for purposes such as shopping for other insurance bids. The members of the Organized Health Care Arrangement are:

- CareFirst, Inc.
- CareFirst BlueChoice Insurance Company
- Kaiser Permanente®
- Dental Network of America, Inc.
- National Vision Administrators, L.L.C.
- Beacon Health Options, Inc.

Effective Date

The effective date of this Notice is April 14, 2003.

Health Insurance Marketplace Coverage Options and Your Health Coverage

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.56% (for 2018) of your household income for the year, or if the coverage your employer provides does not meet the minimum value standard set by the Affordable Care Act, you may be eligible for a tax credit.*

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution as well as your employee contribution to employer-offered coverage is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

How Can I Get More Information?

For more information about your coverage offered by your employer, www.baltimorecityschools.org.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.