Services	In-Network You Pay [1]
HOSPITALIZATION ? (Members are responsible for both physician and facility fees)	
Outpatient Facility Services	$20 per visit
Outpatient Physician Services	
Inpatient Facility Services	No charge*
Inpatient Physician Services	No charge*
HOSPITAL ALTERNATIVES	
Home Health Care	No charge*
Hospice	No charge*
Skilled Nursing Facility	No charge*
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	No charge*
Nursery Care of Newborn	No charge*
Artificial and Intrauterine Insemination[9] (limited to 6 attempts per live birth)	50% of Allowed Benefit
In Vitro Fertilization Procedures[9]	50% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER ? (Members are responsible for applicable physician and facility fees)	
Inpatient Facility Services	No charge*
Inpatient Physician Services	No charge*
Outpatient Facility Services	No charge*
Outpatient Physician Services	No charge*
Office Visits[5,6]	Virtual Connect through CloseKnit- No charge* (closeknithealth.com) All other providers - $15 per visit
Medication Management	$15 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	No charge*
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing-impaired ear every 36 months)	No charge*
VISION	
Routine Exam (limited to 1 visit/benefit period)	$10 per visit
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amou

Exclusions and Limitations

10.1 Coverage Is Not Provided For:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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C. Except for covered Emergency Ser