CareFirst

Group Hospitalization and Medical Services, Inc.

BluePreferred

PPO $250

Group Copy

10455 Mill Run Circle
Owings Mills, Maryland 21117

Para información o preguntas en Español, por favor llame al número del servicio al cliente que aparece en su tarjeta de afiliación de CareFirst BlueCross BlueShield.

For information or questions in Spanish, please call the Member Services telephone number on your CareFirst BlueCross BlueShield member identificiation card.

CUT0219-9S (05/12)

Group Hospitalization and Medical Services, Inc.

doing business as

CareFirst BlueCross BlueShield (CareFirst)

840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan

An independent licensee of the Blue Cross and Blue Shield Association

GROUP CONTRACT

The consideration for this Group Contract is: (1) the Group Contract Application; (2) the payment of Premiums when they are due; and (3) the fulfillment of the Group's obligations, set forth herein. CareFirst BlueCross BlueShield (CareFirst) agrees to provide the benefits described in this Group Contract for a period of twelve (12) months beginning on the Group Effective Date stated in the Group Contract Application and from year to year after that, unless the Group Contract is amended or terminated in accordance with the terms of this Group Contract.

Group Name:	THE SCIENTIFIC CONSULTING GROUP, INC.
Group Number:	3V98
Product Name:	BluePreferred PPO $250
Group Effective Date:	December 1, 2015

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer

These provisions govern the relationship between the Group and CareFirst. As such, they may not be contained in the benefit guides that are provided for the use of Members.

I. Entire Contract. The entire contract between the Group and CareFirst consists of this Group Contract (hereafter, the "Group Contract"), the Group Contract Application, the Evidence of Coverage and all duly authorized attachments referred to therein, and any duly authorized riders, endorsements, and amendments attached to this Group Contract or to the Evidence of Coverage.

II. Definitions. In addition to the definitions contained in the Evidence of Coverage, the underlined terms, when capitalized in this Group Contract, are defined as follows:

Benefit Materials means (i) any enrollment or other coverage information or materials provided by CareFirst to the Group for delivery to Eligible Persons, (ii) the Evidence of Coverage, and (iii) any benefit summaries or other notices or materials relating to the Evidence of Coverage required by federal or state law or regulation to be provided by the Group or CareFirst to Eligible Persons.

Blue Cross and Blue Shield Association means the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Eligible Person means a person identified in the Evidence of Coverage as eligible to enroll including, but not limited to: (i) employees, (ii) former employees whose eligibility for group coverage has been extended due to COBRA requirements or the Maryland Continuation of Coverage provisions stated in the Evidence of Coverage, and (iii) their eligible Dependents.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Evidence of Coverage means the Evidence of Coverage attached to this Group Contract, including all duly authorized attachments, amendments, and riders.

Group means the employer or other organization named on the Group Contract Application and to which CareFirst has issued the Group Contract and Evidence of Coverage.

Group Contract Application means the Group Contract Application submitted by the Group to CareFirst pursuant to which CareFirst has issued this Group Contract. The Group Contract Application is a part of this Group Contract.

Member means a person who meets all applicable eligibility requirements, who is enrolled either as a Subscriber or a Dependent, and for whom the Premiums have been received by CareFirst.

Premium means the dollar amounts the Group remits on behalf of the Member for benefits offered under the Group Contract.

Rescind or Rescission means a termination, cancellation or discontinuance of coverage that has 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. Coverage is not Rescinded and a cancellation or discontinuance of coverage is not a Rescission if:

A. The termination, cancellation or discontinuance of coverage only has a prospective effect; or

B. The termination, cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due, by the Group.

Subscriber means a Member who is enrolled under the Evidence of Coverage as an eligible employee or eligible participant of the Group, rather than as a Dependent.

III. Enrollment Requirements. Eligible employees and their Dependents are those persons who meet the criteria shown in the Evidence of Coverage, except as otherwise shown in the Group Enrollment Application.

A The composition of the Group, the Group's eligibility requirements, and the structure of the Group's benefit offerings to potential Members, that are stated in this Group Contract or in the Group Contract Application are material to the execution of this Group Contract by CareFirst.

B. CareFirst reserves the right to inspect the records of the Group after sixty (60) days from the effective date of the Group coverage in order to verify the eligibility of employees and their Dependents. In addition, the Group may be required by CareFirst to complete and return to CareFirst an eligibility audit and/or census report annually.

IV. Group Cooperation - Benefit Materials.

A. The Group shall: (1) deliver to Eligible Persons all Benefit Materials within the timeframes and in the manner specified by law or regulation, and/or as instructed by CareFirst; and (2) allow CareFirst reasonable access to the Group's employees and other eligible persons for purposes of enrollment. The Group shall promptly provide any information requested by CareFirst to prepare any Benefit Materials.

B. The Group shall maintain a record of its distribution of Benefit Materials to Eligible Persons. The Group shall provide such records to CareFirst within fifteen (15) days of request.

C. The Group shall indemnify, defend, and hold harmless CareFirst from all claims, damages, losses and liabilities, including reasonable attorney's fees, arising out of any failure by the Group to provide any Benefit Materials to Eligible Persons within the timeframes specified by law or regulation and/or as instructed by CareFirst.

V. Group's Cooperation Obligation Relating to Medicare Secondary Payer and Section 111 Reporting Obligations. This Section applies to CareFirst's reporting obligations under Section 111 of the Medicare, Medicaid and SCHIP Expansion Act of 2007, and related regulations and the coordination of benefits under section 1862(b) of the Social Security Act (collectively 'Section 111").

A. The Group agrees to provide the following information to CareFirst when requested:

1. The Group's federal Employer or Tax Identification Number (TIN).

2. The identification, including Employer or Tax Identification Number (TIN), of all parent entities, subsidiary entitles, and any affiliated entities, regardless of location, and if the Group filed a consolidated federal tax return with any other entity in the past twelve (12) months, the identification of the entity or entities with whom the consolidated federal tax return was filed.

3. The Group's number of employees, defined as the total number of people employed (both full-time and part-time) by the Group and any parent entities, subsidiary entitles, and any affiliated entities, regardless of location.

4. The employment status (i.e. active, retired, COBRA) of all employees and the effective and termination dates of status.

5. The disability status of all employees and dependents, if known, and the effective and/or termination dates of each identified person's disability status.

6. The social security number (SSN) or Health Insurance Claim Number (HICN) for each person covered under the Evidence of Coverage.

B. The Group shall promptly report to CareFirst any change in the number of employees, defined as the total number of people employed (both full-time and part-time) by the Group and any parent entities, subsidiary entities, and any affiliated entities, regardless of location, increases from the number reported to CareFirst to (i) more than twenty (20) employees; or (ii) more than one-hundred (100) employees.

C. For purposes of its reporting and coordination of benefits obligations under Section 111, CareFirst, in its sole discretion, shall determine the number of employees attributable to the Group. This means that CareFirst may treat all employees eligible to enroll under a single health care plan purchased by the Group even though the Group consists of more than one distinct corporate entity. Likewise, CareFirst may combine different corporate entities that have separate health care plans into a single employee group where those different corporate entities are commonly owned or file a consolidated tax return. The Group waives any right to assert any claim against CareFirst based upon any determination made by CareFirst relating to Group's employer size for purposes of Section 111.

D. CareFirst shall, in its sole discretion, coordinate benefits relating to Medicare based upon the employer size information it has received from the Group, and any other information in its possession. The Group waives any right to assert any claim against CareFirst based upon any determination made by CareFirst relating to the coordination of benefits as it relates to Medicare.

E. Indemnification of CareFirst by the Group. The Group agrees to indemnify, defend, and hold harmless CareFirst and its officers, directors, agents, employees, and affiliates from all demands, claims, damages to persons or property, losses, liabilities, or expenses, including reasonable attorney's fees, arising out of or caused by: (1) any failure or error by the Group in providing the information requested by CareFirst under this section; and (2) any error by CareFirst in coordinating benefits relative to Medicare due to any error or failure by the Group in reporting its employer size to CareFirst.

VI. Group Administration.

A. In any case in which the Eligible Person will be responsible for a portion of the monthly Premiums upon enrollment, the Group shall make the appropriate payroll deductions, if applicable, for enrolled Members.

B. In the event CareFirst refunds to the Group a Premium, or a portion of a Premium, attributed to the enrollment of a Subscriber or his or her Dependents, the Group agrees to pay, credit or allocate the Subscriber's contributed share of the refunded Premium to the Subscriber.

C. The Group agrees to furnish CareFirst on a monthly basis, and on CareFirst's approved forms, such information as may reasonably be required by CareFirst for the administration of the coverage provided under this Group Contract.

D. The Group agrees to receive on behalf of all Eligible Persons any notices or other materials furnished by CareFirst and to deliver such notices or materials to these individuals.

E. The Group shall furnish CareFirst with all enrollment information necessary to calculate Premiums or any other payments due under the Group Contract. Clerical errors or delays by the Group when providing such information to CareFirst will not invalidate coverage which would otherwise be in effect. Upon discovery of any errors or delays, an equitable adjustment of charges and benefits will be made.

F. The Group shall notify CareFirst, no later than the end of the election period, when a Member has elected to continue coverage under state or federal law or regulation.

G. In addition, CareFirst may at reasonable times examine the Group's pertinent records (including payroll records) with respect to eligibility and Premium payments under this Group Contract. CareFirst may establish reasonable requirements of proof to confirm the eligibility of Members. The Group shall provide, within thirty-one (31) days of request, any information that verifies its compliance with the enrollment guidelines.

VII. Group's Responsibility to Employees. In any case in which the employee will be responsible for a portion of the monthly Premiums upon enrollment, the Group must:

A. Advise the employee of his/her eligibility for coverage under the Group Contract;

B. Advise the employee when he or she may enroll for such coverage in accordance with the provisions stipulated in the Group Contract Application or the Group Contract.

C. Advise the employee when coverage will commence based on the aforementioned provisions and the date of completion of the enrollment form;

D. Advise the employee of the cost of such coverage to the employee and the method in which payment is to be made; and

E. Obtain from the employee a completed enrollment form and a signed agreement by the employee to pay the applicable portion of the monthly Premium.

VIII. Member Effective Dates. Coverage for Eligible Persons enrolled under the Evidence of Coverage becomes effective on the date stated in the Evidence of Coverage.

IX. Payment Provisions.

A. Monthly Premiums. Initial Premiums are due on or before the effective date of the Group Contract. Subsequent Premiums are due each month on the Premium Due Date. The Premium Due Date is the first day of the month for the period for which the Premium applies. If the Group elects to pay Premiums through an electronic payment, CareFirst may not debit or charge the amount of the Premium due prior to the Premium Due Date, except as authorized by the Group.

B. Grace Period. Except for the initial Premium(s), there is a grace period following the Premium Due Date when overdue Premiums can be paid without loss of coverage.

1. A grace period of thirty-one (31) days following the Premium Due Date will be granted for payment of each monthly Premium due subsequent to payment of the first Premium (hereafter, the "Grace Period"). No Grace Period shall apply if CareFirst does not intend to renew the Group Contract beyond the period for which Premiums have been accepted and notice of the intention not to renew is delivered to the Group at least forty-five (45) days before the Premium is due. During the Grace Period the Group Contract shall continue in force.

2. Unless CareFirst receives a notice directly from the Group of the Group's intention to terminate the Group Contract before the end of the Grace Period, CareFirst will collect the Premium for the Grace Period.

3. If CareFirst receives a notice directly from the Group of the Group's intention to terminate the Group Contract during the Grace Period, CareFirst will collect the Premium for the period beginning on the first (1^{st}) day of the Grace Period until

the date when notice is received, or the date of termination stated in the notice, whichever is later.

4. If the Premium for the Grace Period is paid after the Grace Period ends, CareFirst may charge interest for the Premium, but interest may not begin to accrue during the Grace Period, and the interest rate charged will not exceed an effective rate of six percent (6%) per year.

5. Non-Payment of Premiums. If Premiums are not received by the Premium Due Date and CareFirst does not receive a notice directly from the Group of the Group's intention to terminate the Group Contract, CareFirst will notify the Group in writing of the overdue Premiums. If CareFirst receives payment of all amounts listed on the notice prior to the end of the Grace Period, coverage will continue without interruption. If CareFirst does not receive full payment prior to the end of the Grace Period, CareFirst will, upon notice to the Group, terminate the Group Contract, effective as of 11:59 p.m. Eastern Time on the last day of the Grace Period. Members will be liable for the cost of any benefit provided or paid by CareFirst for services received after the effective date of termination subject to the extension of benefits provision. The Group will be liable for all Premiums or other outstanding charges incurred up to and including the date of termination.

C. Payment of all Premiums is a condition precedent to the performance of CareFirst's duties and obligations hereunder. The Group will remit a Premium for each Member under the terms of this Group Contract.

D. Premium Adjustments. All Premium adjustments for Members enrolling or terminating during a coverage month will be calculated on a pro-rated basis. Calculated Premium adjustments will be applied to the next month's Group Premium charges as follows:

1. New enrollment will result in additional Premium charges due; and

2. Terminations will result in a credit toward the Premium charges due.

E. Retroactive Termination of Members. When the Group fails to provide prospective notice of a Member's termination, CareFirst will only retroactively terminate a Member's coverage at 11:59 p.m., Eastern Time, on the last day of the month prior to the month in which the notice of termination is received by CareFirst or; if claims have been received and processed, the day after such processing.

For example, if CareFirst receives retrospective notice of termination on December 16, CareFirst will only retroactively terminate a Member's coverage to November 30. However, if claims have been received and processed after such date, then CareFirst will terminate coverage the day after such processing. For example, if claims are received and processed December 5, termination will be December 6.

The Group agrees to indemnify and hold harmless CareFirst, its subsidiaries, officers, employees, agents and contractors from any and all claims, actions, damages, liabilities, and expenses whatsoever (including reasonable attorney fees) incurred or for which liability for the payment of has been determined, as a result of any act or omission on the part of the Group or its subsidiaries, officers, employees, agents and contractors in connection with or related to any failure to comply with any provisions of law, regulation or administrative directive, relating to or concerning the providing of timely and adequate certificates of creditable coverage and as the same is more fully addressed and set forth under the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any future amendments thereto.

F. Premium Rate Changes. There may be a rate increase when approved by the Maryland Insurance Administration, as provided by law. CareFirst will not increase the Group's

Premium rate during the 12-month period beginning on the effective date of this Group Contract. CareFirst may increase the Group's Premium more frequently if the increase is due solely to the enrollment of new Members.

CareFirst will provide notice of a change to Premium rates by giving the Group at least forty-five (45) days prior written notice. CareFirst will also prominently post notice of the Premium change and justification for such on the CareFirst website.

X. Misstatement of Age. If the benefits or Premium set out in this Group Contract vary based on the Member's age, and if the age of a Member is misstated by the Subscriber, eligible Dependent, or Group, an equitable adjustment of the benefits or Premium will be made by CareFirst. Any benefit determinations or Premium charges made based on the Member's misstated age will be adjusted by CareFirst as soon as reasonably possible by recalculating the benefit or Premium using the correct age, and written notification will be sent to the Member.

XI. Premium Rebates. This Section applies if CareFirst is required under federal or state law or regulation to rebate any portion of a Premium paid under the Group Contract by the Group or any Subscribers (a "Rebate").

A. Cooperation in Distribution of Rebates. The Group agrees to assist CareFirst with the distribution of any Rebate. The Group will timely provide all information requested by CareFirst, in the format requested by CareFirst, related to the distribution of any Rebate. This information shall include, but is not limited to whether the Group is governed by ERISA, and Subscriber address information.

B. Determination of Rebate Amount. CareFirst is solely responsible for determining, under applicable law, whether any Rebate is due to the Group or any Subscriber and the amount of any Rebate.

C. Distribution of Rebates. CareFirst will pay any Rebate to the Group and/or to Subscribers, as follows:

1. If the Group has determined that it is not a health plan governed by ERISA, CareFirst will, in its sole discretion and under applicable law, distribute the Rebate to the Group, only if the Group provides written documentation to CareFirst, with the assurances required by subsection D, below. If the Group does not provide such documentation, CareFirst will distribute the Rebates directly to the Members. The Group agrees to be bound by determinations regarding the distribution of any Rebate. If this Group Contract has been terminated as of the date that the Rebate is to be paid and CareFirst is unable to distribute the Rebate to the Group, the Rebate will be distributed directly to the Member.

2. If the Group has determined that it is a health plan governed by ERISA, CareFirst will, in its sole discretion and under applicable law, distribute the Rebate to the Group.

3. CareFirst will provide the U.S. Department of Health and Human Services standard notice of Rebate distribution to each Member.

D. Assurances by Group. If CareFirst distributes a Rebate to the Group, the Group will retain, use or distribute all portions of the Rebate in compliance with governing law. The Group represents and provides assurances that (i) it has made a determination regarding whether it is a group health plan that is governed by ERISA; (ii) if the Group determines that it is governed by ERISA, the Group will distribute any Rebate in accordance with its obligations under ERISA; and (iii) if the Group has determined that it is not governed by ERISA, the Group will dispose of any Rebate in accordance with its obligations under 45 C.F.R. § 158.242, as amended or restated from time to time. The Group agrees to

provide CareFirst, upon request, with any further written assurance regarding these matters at the time any Rebate is distributed by CareFirst to the Group.

E. Tax Procedure. The parties agree that CareFirst is not the statutory employer of any Subscriber. To the extent that any portion of a Rebate paid to a Subscriber by CareFirst or the Group is taxable as wages, the Group shall be treated as the sole employer who paid those wages and for whom work was performed. The Group agrees that it will: (1) determine the taxable portion of any Rebate; and (2) provide, where required by law, appropriate tax withholding and reporting relating to any Rebate paid to the Group or Subscribers (including, but not limited to, the preparation and submission of any Forms W-2, 1099, or similar federal and state tax forms used to report the receipt of wages or income).

F. Indemnification of CareFirst by the Group. The Group agrees to indemnify, defend, and hold harmless CareFirst and its officers, directors, agents, employees, and affiliates from all demands, claims, damages to persons or property, losses, liabilities, or expenses, including reasonable attorney's fees, arising out of or caused by: (1) any failure by the Group to use, allocate, distribute, or otherwise dispose of a Rebate (including, but not limited to, the Group's performance of any tax reporting obligation stated in subsection E, above, of this section) in the manner required by law; or (2) a breach of any assurance or representation given by the Group to CareFirst made in subsection D, above, of this section or otherwise provided to CareFirst relating to any Rebate.

XII. Amendment Procedure. Amendments must be consistent with state law. CareFirst may amend the Group Contract with respect to any matter, other than changes to Premium rates, by mailing or, if consent has been given, by e-mailing to the Group's last known e-mail address a notice, including any amendment(s), where applicable, to the Group at its address of record with CareFirst at least forty-five (45) days before the amendment(s) are to take effect. CareFirst will provide notice regarding Premium rate changes as set forth in Section IX.F.

A. All such amendments are deemed accepted by the Group unless the Group gives CareFirst written notice of non-acceptance within fifteen (15) days following the notice date, in which event the Group may cancel the Group Contract effective as of the renewal date, upon written notice to CareFirst. If state or federal law mandates an amendment, it will be automatically deemed accepted by the Group.

B. Regardless of when the amendment is received, the Evidence of Coverage and this Group Contract are considered to be automatically amended as of the date specified in the contract amendment or the notice (if not stated in the contract amendment), unless otherwise mandated, to conform with any applicable changes to state or federal law.

C. No agent or other person, except an officer of CareFirst, has authority to waive any conditions or restrictions of the Group Contract, or to extend the time for making payments hereunder, or to bind CareFirst by making any promise or representation or by giving or receiving any information. No change in the Group Contract will be binding on CareFirst, unless evidenced by an amendment signed by an authorized representative of CareFirst.

XIII. Contract Renewal. CareFirst will send notice of the renewal of this Group Contract no later than forty-five (45) days prior to the Contract Renewal Date, except as outlined in the Termination or Rescission of Group Contract provision below.

XIV. Termination or Rescission of Group Contract. The Group Contract may be terminated as follows:

A. The Group may terminate the Group Contract at any time. Such termination shall be effective at midnight on the termination date specified by the Group. The Group will be responsible for providing a notice to each Member.

B. CareFirst may terminate the Group Contract for one of the following reasons:

1. Failure of the Group to pay Premiums or any other payment due under the terms of the Group Contract.

2. The Group has failed to comply with a material plan provision in the Group Contract relating to group participation rules, in which case, termination will be immediate.

3. CareFirst elects not to renew all group health insurance coverage in the state. In this case, CareFirst will provide notice of the nonrenewal at least one hundred eighty (180) days before the date of the nonrenewal to the affected individuals and Group, give notice to the Insurance Commissioner of Maryland at least thirty (30) working days before the notice referred to above, not sell new business for groups in the state for a five (5) year period beginning with the date of such notice to the Commissioner, and act uniformly without regard to the claims experience of any affected Group, or any Health Status-Related factor of any affected individual.

C. Rescission of Group Contract. CareFirst may Rescind this Group Contract for one of the following reasons:

1. The Group has performed an act, practice, or omission that constitutes fraud; or

2. The Group has made an intentional misrepresentation of material fact under the terms of coverage.

In case of Rescission, CareFirst will provide thirty (30) days advance written notice of any Rescission to each Subscriber who would be affected by the Rescission. This Group Contract will be terminated effective on the date on which CareFirst determines that the act, practice, or omission that constitutes fraud or the intentional misrepresentation material fact (a) occurred, or (b) was relied upon by CareFirst, whichever is earlier.

This Group Contract may not be Rescinded in the absence of fraud or an intentional misrepresentation of material fact and without thirty (30) days advance written notice.

D. The Group will be liable for all Premiums and other outstanding charges up to and including the date of termination. The Group and/or Members will be liable for the cost of any services provided or paid by CareFirst for services received on or after the date of termination except as provided in the Evidence of Coverage.

XV. Insolvency. In the event of insolvency, CareFirst's rights under the Group Contract (including, but not limited to, all rights to Premiums to the extent permitted by applicable bankruptcy law) shall become vested in any person or entity that guarantees payment and actually pays for the services and benefits that CareFirst is obligated to make available under the Group Contract.

XVI. Contestability of Coverage. This Group Contract may not be contested, except for nonpayment of Premiums, after it has been in force for two (2) years from its date of issue. Any rescission of coverage of the Group or of any Member shall only be based upon an act, practice or omission that constitutes fraud or is due to an intentional misrepresentation of material fact. Absent fraud, each statement made by an applicant, Group, or Member is considered to be a representation and not a warranty. A statement made to effectuate coverage may not be used to avoid the coverage or reduce benefits under this Group Contract unless the statement is contained in a written instrument signed by the Group or Member, and a copy of the statement is given to the Group or Member. CareFirst shall give thirty (30) days advance written notice of any rescission of coverage of the Group or any Member. This provision does not preclude the assertion at any time of defenses to any claim based upon the person's ineligibility for coverage under this Group Contract or upon other provisions in this Group Contract.

XVII. Blue Cross and Blue Shield Association Plan Disclosure. The Group, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Group Contract constitutes a contract solely between the Group and CareFirst; that CareFirst is an independent corporation operating under a license from the Blue Cross and Blue Shield Association permitting CareFirst to use the Blue Cross and Blue Shield Service Marks in the District of Columbia, Maryland, and portions of Virginia; and that CareFirst is not contracting as the agent of the Blue Cross and Blue Shield Association. The Group, on behalf of itself and its Members, further acknowledges and agrees that it has not entered into this Group Contract based upon representations by any person other than CareFirst; and no person, entity, or organization other than CareFirst shall be held accountable or liable to the Group for any of CareFirst's obligations to the Group created under this Group Contract. This paragraph shall not create any additional obligations whatsoever on the part of CareFirst other than those obligations created under other provisions of this Group Contract.

XVIII. Regulatory Compliance. CareFirst has not provided any document intended to constitute a Plan Document or a Summary Plan Description for purposes of ERISA, if the Group is a health care plan governed by ERISA. The Group is the party responsible for the preparation of the Plan Document and the preparation and distribution of the Summary Plan Description.

For purposes of ERISA and/or COBRA (or comparable provisions of other state or federal law), the Group is the "plan sponsor" and the "administrator" of the group health benefits plan, the benefits of which are set out in this Group Contract. It is the Group's responsibility to comply with all applicable law and regulation, including, but not limited to, all disclosure and reporting requirements under both ERISA and COBRA (or comparable provisions of other state or federal law). In particular, upon enrollment and upon the occurrence of a "qualifying event" (as that term is defined under COBRA), it is the Group's responsibility to notify Members of their rights under COBRA and to determine whether, and to what extent, they are eligible to elect and/or continue coverage under COBRA. Further, it is the Group's responsibility to determine whether an order received by the Group with respect to employees of the Group and their children is a "qualified medical child support order" (as that term is defined under ERISA and/or applicable state law) and whether such children are eligible for coverage under this Group Contract. The parties expressly understand and agree that this Group Contract, including the portions that are to be distributed to the Members, do not necessarily satisfy all requirements for a "written plan document" or a "summary plan description" (as those terms are defined under ERISA).

XIX. Prohibition Against Discrimination.

A. General. CareFirst will not discriminate for any purpose, including but not limited to, enrollment, eligibility, variations in Premium rates, and/or coverage under the terms of the Evidence of Coverage, on the basis of race, color, sex, sexual orientation, gender expression, gender identity, religion, disability, age, veteran status, ancestry, or national or ethnic origin.

B. Highly-Compensated Individuals. The Group hereby expressly acknowledges its obligation and responsibility to comply with the non-discrimination requirements of Section 2716 of the Public Health Service Act, which prohibits discrimination in favor of highly compensated individuals.

The Group agrees to indemnify, defend, and hold harmless CareFirst and its officers, directors, agents, employees, and affiliates from all demands, claims, damages to persons or property, losses, liabilities, or expenses, including reasonable attorney's fees, arising out of or caused by any failure by the Group to comply with the obligations and responsibilities stated in this section, in the manner required by law.

C. Health Status. CareFirst will not discriminate against any Member for purposes including, but not limited to, eligibility, enrollment, variations in Premium rates, and/or coverage under the terms of the Evidence of Coverage, based on health status, medical

condition (including both, mental and physical illness), claims experience, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) or disability.

D. Premium Subsidies. CareFirst will not discriminate against or in favor of any individual eligible to enroll under the Evidence of Coverage for purposes including, but not limited to, eligibility, enrollment, variations in Premium rates, and/or coverage under the terms of the Evidence of Coverage, on the basis of such individual's eligibility for, or receipt of federal premium subsidies.

XX. Notices.

A. Notices to Subscribers required under this Group Contract shall be in writing directed either to the Subscriber's last known address or, if consent has been given, by e-mail to the Subscriber's last known e-mail address. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst of an address or e-mail address change. The notice will be effective on the date mailed or sent by e-mail, whether or not the Member in fact receives the notice or there is a delay in receiving the notice.

B. Notices to the Group will be sent either by first class mail to the address set forth in the Group Contract Application or, if consent has been given, by e-mail to the Group's e-mail address. Notice will be effective on the date of receipt by the Group, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service.

1. The Group may change the address or, in the manner specified in the Group's consent to receive electronic notices, the Group's e-mail address at which notice is to be given by providing written notice thereof to CareFirst.

2. If the Group is a brokered account, notices to the Group required or arising under the Group Contract will be effectively given by CareFirst by sending such notice directly to the Group as set forth above or, alternatively, by providing notice in the manner described above to the Group's current broker of record as recognized and listed in CareFirst's records. The Group will promptly notify CareFirst of any change in the designated broker under the Group Contract.

C. Except with regard to the Group's consent to receive electronic notices, when notice is sent to CareFirst, it must be sent by first class mail to:

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065

Notice will be effective on the date of receipt by CareFirst, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service. CareFirst may change the address at which notice is to be given by providing written notice to the Group.

D. CareFirst will notify the Group in writing of any changes that may result in a reduction of benefits no less than ninety (90) days before the date on which the change will become effective.

XXI. Electronic Notices. If the Group has agreed to receive electronic notices:

A. CareFirst may send the following notices and documents may be provided electronically to the Group:

1. Communications required by this Group Contract, the Evidence of Coverage, or federal or state law.

2. Communications relating to the products or services the Group receives from CareFirst, including but not limited to enrollment, wellness program information and notices (including disease management and wellness preventive information), and similar notices.

3. Information on new or additional products, services, or programs offered by CareFirst.

B. The Group may revoke its consent to receive the electronic notices at any time.

C. The Group can change its consent elections or its email address online, at any time.

D. The Group may obtain a paper copy of any electronically furnished notice or document free of charge.

E. In order to access information provided electronically, the Group must have the following:

1. A computer with Internet access

2. An email account that allows the Group to send and receive emails

3. Internet Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

XXII. Amendments and Modifications. No amendment or modification of any term or provision is valid until approved by an executive officer of CareFirst and unless the approval is endorsed on the policy and attached to the Evidence of Coverage or Group Contract. No other person has authority to change this Evidence of Coverage or Group Contract or waive any of its provisions.

Oral statements cannot be relied upon to modify or otherwise affect the benefits, limitations, and/or exclusions of this Group Contract or the Evidence of Coverage, or to increase or void any coverage or reduce any benefits under this Group Contract or the Evidence of Coverage. Such oral statements cannot be used in the prosecution or defense of a claim under this Group Contract or the Evidence of Coverage.

XXIII. Group Statement. The Group agrees that in the making of this Group Contract, it is acting for and on behalf of itself and as the agent representative of its Eligible Persons; and it is agreed and understood that the Group is not the agent or representative of CareFirst for any purpose of this Group Contract.

XXIV. Assignment. The Group Contract is not assignable by the Group without the written consent of CareFirst.

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan

An independent licensee of the Blue Cross and Blue Shield Association

2015 GROUP CONTRACT AMENDMENT

This amendment is effective. If no date is shown, this amendment is effective on the effective date or renewal date of the Group Contract to which this amendment is attached.

The Group Contract is amended as follows:

1. Section X.B of the Group Contract is deleted and replaced with the following:

   B. Grace Period. Except for the initial Premium(s), there is a grace period following the Premium Due Date when overdue Premiums can be paid without loss of coverage.

      1. A grace period of thirty-one (31) days beginning on the Premium Due Date will be granted for payment of each monthly Premium due subsequent to payment of the first Premium (hereafter, the "Grace Period"). No Grace Period shall apply if CareFirst does not intend to renew the Group Contract beyond the period for which Premiums have been accepted and notice of the intention not to renew is delivered to the Group at least forty-five (45) days before the Premium is due. During the Grace Period the Group Contract shall continue in force.

      2. Unless CareFirst receives a notice directly from the Group of the Group's intention to terminate the Group Contract before the end of the Grace Period, CareFirst will collect the Premium for the Grace Period.

      3. If CareFirst receives a notice directly from the Group of the Group's intention to terminate the Group Contract during the Grace Period, CareFirst will collect the Premium for the period beginning on the first (1^{st}) day of the Grace Period until the date when notice is received, or the date of termination stated in the notice, whichever is later.

      4. If the Premium for the Grace Period is paid after the Grace Period ends, CareFirst may charge interest for the Premium, but interest may not begin to accrue during the Grace Period, and the interest rate charged will not exceed an effective rate of six percent (6%) per year.

      5. Non-Payment of Premiums. If Premiums are not received by the Premium Due Date and CareFirst does not receive a notice directly from the Group of the Group's intention to terminate the Group Contract, CareFirst will notify the Group in writing of the overdue Premiums. If CareFirst receives payment of all amounts listed on the notice prior to the end of the Grace Period, coverage will continue without interruption. If CareFirst does not receive full payment prior to the end of the Grace Period, CareFirst will, upon notice to the Group, terminate the Group Contract, effective as of 11:59 p.m. Eastern Time on the last day of the Grace Period. Members will be liable for the cost of any benefit provided or paid by CareFirst for services received after the effective date of termination subject

to the extension of benefits provision. The Group will be liable for all Premiums or other outstanding charges incurred up to and including the date of termination.

2. Section XIII, Amendment Procedure, in the Group Contract is deleted and replaced with the following:

XIII. Uniform Modification and Amendment Procedure.

A. Uniform Modification. CareFirst reserves the right to modify the Evidence of Coverage at renewal if the modification is consistent with State law and is effective uniformly for all Groups with this product.

1. For purposes of this provision, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:

a) The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and

b) The modification is directly related to the imposition or modification of the Federal or State requirement.

2. For purposes of this provision, other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product meets all of the following criteria:

a) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act);

b) The product is offered as the same product network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);

c) The product continues to cover at least a majority of the same service area;

d) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and

e) The product provides the same covered benefits, except for any changes in benefits that cumulatively impact rate for any plan within the product within an allowable variation of ± 2 percentage points (not including changes pursuant to applicable Federal or State requirements).

B. Amendment Procedure. Amendments must be consistent with state law. CareFirst may amend the Group Contract with respect to any matter, other than changes to Premium rates, by mailing or, if consent has been given, by e-mailing to the Group's last known e-mail address a notice, including any amendment(s), where applicable, to the Group at its address of record with CareFirst at least sixty (60) days before the Contract Renewal Date. CareFirst will provide notice regarding Premium rate changes as set forth in Section X.F. If a material modification required to conform the Group Contract and Evidence of Coverage to changes in applicable state or Federal law is made at a time other than renewal and it affects the content of the summary of benefits and coverage, CareFirst will provide at least sixty (60) days advanced notice of the modification.

1. All such amendments are deemed accepted by the Group unless the Group gives CareFirst written notice of non-acceptance within fifteen (15) days following the notice date, in which event the Group may cancel the Group Contract effective as of the renewal date, upon written notice to CareFirst. If state or federal law mandates an amendment, it will be automatically deemed accepted by the Group.

2. Regardless of when the amendment is received, the Evidence of Coverage and this Group Contract are considered to be automatically amended as of the date specified in the contract amendment or the notice (if not stated in the contract amendment), unless otherwise mandated, to conform with any applicable changes to state or federal law.

3. No agent or other person, except an officer of CareFirst , has authority to waive any conditions or restrictions of the Group Contract, or to extend the time for making payments hereunder, or to bind CareFirst by making any promise or representation or by giving or receiving any information. No change in the Group Contract will be binding on CareFirst , unless evidenced by an amendment signed by an authorized representative of CareFirst.

3. Section XIV, Contract Renewal, in the Group Contract is deleted and replaced with:

XIV. Contract Renewal. CareFirst will send notice of the renewal of this Group Contract no later than sixty (60) days prior to the Contract Renewal Date, except as outlined in the Termination or Rescission provision of the Group Contract.

This amendment is issued to be attached to the Group Contract. This amendment does not change the terms and conditions of the Group Contract, unless specifically stated herein.

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer

Group Hospitalization and Medical Services, Inc.

doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

This Evidence of Coverage, including any duly authorized attachments, notices, amendments and riders, is a part of the Group Contract issued to the Group through which Members are enrolled for covered health benefits. In addition, the Group Contract includes other provisions that explain the duties of CareFirst and the Group. The Group's payment to CareFirst and CareFirst's issuance of the Group Contract make the Group Contract's terms and provisions binding on CareFirst and the Group.

The Group reserves the right to change, modify, or terminate the plan, in whole or in part.

Members should not rely on any oral description of the plan because the written terms in the Group's plan documents always govern.

Group Name: **THE SCIENTIFIC CONSULTING GROUP, INC.**

Group Number: **3V98**

Product Name: **BluePreferred PPO $250**

Group Effective Date: **December 1, 2015**

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer

SECTION 1
DEFINITIONS

The underlined terms, when capitalized, are defined as follows:

Adoption means the earlier of a judicial decree of adoption, or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

Allowed Benefit means:

For a Preferred Provider: 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 that the service is rendered, except for facilities that are paid in accordance with Diagnosis Related Groups ("DRG's"). The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.

For a Non-Preferred Provider that is a health care practitioner:

A. For a Covered Service rendered by an On-Call Physician or a Hospital-Based Physician who accepts an Assignment of Benefits, the Allowed Benefit is:

1. For a Hospital-Based Physician, no less than the greater of:

a) 140% of the average rate CareFirst paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to similarly licensed providers, who are Hospital-Based Physicians under written contract with CareFirst; or

b) The final allowed amount of CareFirst for the same Covered Service for the 12-month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the Hospital-Based Physician billing under the same federal tax identification number the Hospital-Based Physician used in calendar year 2009.

2. For an On-Call Physician, no less than the greater of:

a) 140% of the average rate CareFirst paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to similarly licensed providers under written contract with CareFirst; or

b) The average rate CareFirst paid for the 12-months period that ended on January 1, 2010, in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to a similarly licensed provider not under written contract with CareFirst inflated by the change in the Medicare Economic Index from 2010 to the current year.

The benefit is payable to the On-Call Physician or Hospital-Based Physician who accepts an Assignment of Benefits, except as provided in Section 6.3C, and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.

B. **For a Covered Service rendered by an Ambulance Service Provider: The Allowed Benefit for a Covered Service provided by an Ambulance Service Provider that is a Non-Preferred Provider may not be less than the Allowed Benefit paid to a Preferred Ambulance Service Provider for the same Covered Service in the same geographic region, as defined by the Centers for Medicare and Medicaid Services. The benefit is payable to the Ambulance Service Provider who accepts an Assignment of Benefits, except as provided in Section 6.3C, and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.**

C. **For a Covered Service rendered by a United Stated Department of Defense or United States Department of Veterans Affairs health care provider: The Allowed Benefit for a Covered Service rendered by a Non-Preferred Provider that is a United Stated Department of Defense or United States Department of Veterans Affairs health care provider will be no less than the health care provider's actual charge. Benefit payments will be made directly to a United States Department of Defense and the United States Department of Veteran Affairs health care provider. The benefit is payable to the United Stated Department of Defense or United States Department of Veterans Affairs health care provider and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.**

D. **For a Covered Service rendered by any other Non-Preferred Provider: The Allowed Benefit for a Covered Service is no less than the amount paid to a similarly licensed provider who is a Preferred Provider for the same Covered Service in the same geographic region. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with a health care provider. In that instance, the CareFirst payment will be based on the negotiated fee and the health care provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits. For a Non-Preferred Provider who is a physician, the benefit is payable to the physician if the Member has given an Assignment of Benefits, except as provided in Section 6.3C. For any other Non-Preferred Provider who is a health care practitioner, the benefit is payable to the Member or to the Non-Preferred Provider at the discretion of CareFirst. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Preferred Provider. In any event, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and, unless the fee is negotiated, for any Balance Bill.**

For Emergency Services provided by a Non-Preferred Provider, the Allowed Benefit for a Covered Service will be no less than the amount specified section 2719A of the Public Health Service Act and the regulations promulgated pursuant thereto.

For a Non-Preferred Provider that is a health care facility, the Allowed Benefit for a Covered Service may be a rate set by a regulatory agency and is no less than the allowed amount paid to a similarly licensed provider who is a Preferred Provider that is a health care facility for the same Covered Service in the same geographic region. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with a health care provider. In that instance, the CareFirst payment will be based on the negotiated fee and the health care provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits. The benefit is payable to the Member or to the Non-Preferred Provider 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. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Preferred Provider. In any event, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and, unless the fee is negotiated, for any Balance Bill.

Pediatric Dental Allowed Benefit means:

A. For Preferred Dentists, the Pediatric Dental Allowed Benefit for a Covered Dental Service will be the amount agreed upon between CareFirst and the Preferred Dentist. The benefit payment is made directly to the Preferred Dentist and accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits.

B. For Participating Dentists, the Pediatric Dental Allowed Benefit for a Covered Dental Service will be the lesser of (1) the Dentist's actual charge; or (2) the benefit amount, according to the CareFirst rate schedule for the Covered Dental Service that applies on the date that the service is rendered. The benefit amount on the CareFirst rate schedule will be no less than the amount paid to a Preferred Dentist in the same geographic area for the same service. The benefit payment is made directly to the Participating Dentist and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.

C. For Non-Participating Dentists, the Pediatric Dental Allowed Benefit for a Covered Dental Service will be determined in the same manner as the Allowed Benefit payable to a Participating Dentist. For a Non-Participating Dentist who is a physician, the benefit is payable to the physician if the Member has given an Assignment of Benefits, except as provided in Section 6.3C. For any other Non-Participating Dentist, the benefit is payable to the Member or to the Non-Participating Dentist at the discretion of CareFirst. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Participating Dentist. In any event, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and for any Balance Bill.

Pediatric Vision Allowed Benefit means:

A. For a Contracting Vision Provider, the Pediatric Vision Allowed Benefit for a Covered Vision Service is the lesser of:

1. The Contracting Vision Provider's actual charge; or

2. The benefit amount, according to the Vision Care Designee's Contracting Vision Provider rate schedule for the Covered Vision Service that applies on the date that the service is rendered.

The benefit payment is made directly to a Contracting Vision Provider. When a Member receives a Covered Vision Service from a Contracting Vision Provider, the benefit payment is accepted as payment in full, except for any applicable Copayment or Coinsurance stated in the Schedule of Benefits. The Contracting Vision Provider may collect any applicable Copayment or Coinsurance.

B. For a Non-Contracting Vision Provider, the Pediatric Vision Allowed Benefit for a Covered Vision Service is the lesser of:

1. The Non-Contracting Vision Provider's actual charge; or

2. The benefit amount stated in the Schedule of Benefits. The benefit amounts stated in the Schedule of Benefits, as compared to the benefit amounts provided on the Vision Care Designee's Contracting Vision Provider rate schedule, will be no less than the benefit amounts required to comply with § 14-205 of the Insurance Code.

For a Non-Contracting Vision Provider who is a physician, the benefit is payable to the

physician if the Member has given an Assignment of Benefits, except as provided in Section 6.3C. For any other Non-Contracting Vision Provider, the benefit is payable to the Member or to the Non-Contracting Vision Provider at the discretion of the Vision Care Designee. It is the Member's responsibility to apply any Vision Care Designee payments received to the claim from the Non-Contracting Vision Provider. In any event, the Member is responsible for any Balance Bill

Prescription Drug Allowed Benefit means the lesser of:

A. The Pharmacy's actual charge; or

B. The benefit amount, according to the CareFirst fee schedule, for covered Prescription Drugs that applies on the date that the service is rendered.

When the Member purchases a covered Prescription Drug from a Contracting Pharmacy Provider, the benefit payment is made directly to the Contracting Pharmacy Provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance as stated in the Schedule of Benefits. The Member is responsible for any applicable Deductible, Copayment or Coinsurance and the Contracting Pharmacy Provider may bill the Member directly for such amounts.

When the Member purchases a covered Prescription Drug from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. The Prescription Drug Allowed Benefit for a covered Prescription Drug will be determined in the same manner as the Prescription Drug Allowed Benefit to a Contracting Pharmacy Provider, less any applicable Deductible, Copayment or Coinsurance. The Member will be entitled to reimbursement from CareFirst or its designee for the amount up to the Prescription Drug Allowed Benefit, minus any applicable Deductible, Copayment or Coinsurance and the Member is responsible for any balances above the Prescription Drug Allowed Benefit.

Ambulance means any conveyance designed and constructed or modified and equipped to be used, maintained, or operated to transport individuals who are sick, injured, wounded, or otherwise incapacitated.

Ambulance Service Provider means a provider of Ambulance services that:

A. is owned, operated, or under the jurisdiction of a political subdivision of the State of Maryland or a volunteer fire company or volunteer rescue squad; or

B. has contracted to provide Ambulance services for a political subdivision of the State of Maryland.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory and 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.

Annual Open Enrollment Period means the period of no less than thirty (30) days each year prior to the Group's Contract Renewal Date during which an eligible individual may enroll or change coverage under this Evidence of Coverage.

Assignment of Benefits means the transfer of health care coverage reimbursement benefits or other rights under this Evidence of Coverage by, or on behalf of, the Member to a physician, a Hospital-Based Physician, an On-Call Physician or an Ambulance Service Provider, pursuant to Annotated Code of Maryland, Insurance Article §14-205.2, §14-205.3 or §15-138.

Balance Bill means:

A. For Covered Services, the difference between a Non-Preferred Provider's actual charge for a Covered Service and the Allowed Benefit.

B. For Covered Dental Services, the difference between a Non-Participating Dentist's actual charge for a Covered Dental Service and the Pediatric Dental Allowed Benefit.

C. For a Covered Vision Service, the difference between a Non-Contracting Vision Provider's actual charge for a Covered Vision Service and the Pediatric Vision Allowed Benefit.

Benefit Period means, except for the Covered Vision Services described below, the contract year during which coverage is provided for Covered Services, Covered Dental Services and Covered Vision Services. The annual vision examination may occur at any time during this Benefit Period. For Covered Vision Services other than the annual vision examination, the Benefit Period is 12-months dating from the first Covered Vision Service.

Bereavement Counseling means counseling provided to the Immediate Family or Family Caregiver of the Member after the Member's death to help the Immediate Family or Family Caregiver cope with the death of the Member.

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

Brand Name Drug means a Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and that may be used and protected by a trademark.

Calendar Year means January 1 through December 31 of each year.

Cardiac Rehabilitation means 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 means Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield.

Caregiver means a person who is not a health care provider, who lives with or is the primary Caregiver of the terminally-ill Member in the home. The Caregiver can be a relative by blood, marriage, or Adoption (see Family Caregiver definition), or a friend of the Member, but cannot be a person who normally charges for providing services. However, at CareFirst's discretion, a Caregiver may be an employee of a hospice care hospital/agency.

Coinsurance means the percentage of the Allowed Benefit allocated between CareFirst and the Member, whereby CareFirst and the Member share in the payment for Covered Services, Covered Dental Services or Covered Vision Services.

Congenital or Genetic Birth Defect means a defect existing at or from birth, including a hereditary defect, which includes, but is not limited to, autism or an autism spectrum disorder and cerebral palsy.

Contract Renewal Date means the date on which the Group Contract renews and each anniversary of such date.

Contracting Pharmacy Provider means a separate independent Pharmacist or Pharmacy that has contracted with CareFirst or its designee to provide covered Prescription Drugs.

Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are rendered when acting within the scope of such license; and, that has contracted with the Vision Care Designee to provide Covered Vision Services.

Controlled Clinical Trial means a treatment that is:

A. Approved by an institutional review board;

B. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and

C. Is approved by;

1. The National Institutes of Health or a Cooperative Group.

2. The Centers for Disease Control and Prevention.

3. The Agency for Health Care Research and Quality.

4. The Centers for Medicare & Medicaid Services.

5. Cooperative group or center of any of the entities described in clauses C.1 through C.4 above or the Department of Defense or the Department of Veterans Affairs.

6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

7. The Department of Veterans Affairs, the Department of Defense or the Department of Energy if that the study or investigation has been reviewed and approved through a system of peer review that has been determined:

a) To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

b) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

8. The FDA in the form of an investigational new drug application.

9. 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 means any item that increases physical comfort or convenience without serving a Medically Necessary purpose (e.g., elevators, hoyer/stair lifts, ramps, shower/bath benches, and items available without a prescription).

Cooperative Group means 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, National Cancer Institute Community Clinical Oncology Program, AIDS Clinical Trials Group, and Community Programs for Clinical Research in AIDS.

Copayment (Copay) means the fixed dollar amount that a Member must pay for certain Covered Services, Covered Dental Services or Covered Vision Services.

Cosmetic means 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.

Co-Surgery means when two or more surgeons of the same or different specialties are required to perform the same surgical procedure.

Covered Dental Services means Medically Necessary services or supplies listed in Section 2 of the Description of Covered Services.

Covered Services means Medically Necessary services or supplies provided in accordance with the terms of this Evidence of Coverage, other than Covered Dental Services or Covered Vision Services.

Covered Vision Services means Medically Necessary services or supplies listed in Section 3 of the Description of Covered Services.

Custodial Care means care provided primarily to meet the personal needs of the patient. Custodial Care does not require skilled medical or paramedical personnel. Such care includes help in walking, bathing, or dressing. Custodial Care also includes preparing food or special diets, feeding, administering medicine, or any other care that does not require continuing services of medically trained personnel.

Deductible means the dollar amount of the Allowed Benefits payable during a Benefit Period for Covered Services or Covered Dental Services that must first be incurred by the Member before CareFirst will make payments for Covered Services or Covered Dental Services.

Dental Director is a Dentist appointed by the Medical Director of CareFirst to perform administrative duties with regard to the dental services listed in this Evidence of Coverage.

Dental Specialist means a Dentist who is certified or trained in a specific field of dentistry.

Dentist means an individual who is licensed to practice dentistry as defined by the respective jurisdiction where the practitioner provides care.

Dependent means an eligible Spouse or Dependent Child as defined in Sections 2.2 and 2.3. The eligibility of Dependents to enroll is stated in the Eligibility Schedule.

Dependent Child or Dependent Children means an eligible individual who is the child of the Subscriber or the Subscriber's Spouse as defined in Section 2.3.

Diabetic Supply or Diabetic Supplies means all Medically Necessary and appropriate supplies prescribed by a health care provider for the treatment of diabetes, including but not limited to lancets, alcohol wipes, test strips (blood and urine), syringes and needles.

Domiciliary Care means services that are provided to aged or disabled individuals in a protective, institutional or home-type environment. Domiciliary Care includes:

A. Shelter;

B. Housekeeping services;

C. Board;

D. Facilities and resources for daily living; and

E. Personal surveillance or direction in the activities of daily living.

Durable Medical Equipment means equipment furnished by a supplier or a home health agency that:

A. Is primarily and customarily used to serve a medical purpose;

B. Is not useful to a person in the absence of illness or injury;

C. Is ordered or prescribed by a physician or other qualified practitioner;

D. Is consistent with the diagnosis;

E. Is appropriate for use in the home;

F. Is reusable; and

G. Can withstand repeated use.

Effective Date means the date on which the Member's coverage becomes effective. Covered Services, Covered Dental Services and Covered Vision Services rendered on or after the Member's Effective Date are eligible for coverage.

Eligible Provider means either a health care practitioner or a health care facility that provides health care services that are within the lawful scope of the services for which such a health care provider is licensed or otherwise authorized by law.

Emergency Medical Condition means the sudden and unexpected onset of a medical condition of sufficient severity, including severe pain, when 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:

A. Serious jeopardy to the mental or physical health of the individual;

B. Danger of serious impairment of the individual's bodily functions;

C. Serious dysfunction of any of the individual's bodily organs or parts; or

D. In the case of a pregnant woman, serious jeopardy to the health of the 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 CareFirst determines.

Emergency Services means, with respect to an Emergency Medical Condition:

A. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

B. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Enrollment Form means the information submitted by or on behalf of an eligible individual to CareFirst and the Group in connection with a request to enroll as either a Subscriber or Dependent.

Evidence of Coverage means this agreement, including all duly authorized attachments, notices, amendments and riders, issued to the Group and the Subscriber by CareFirst under the Group Contract between the Group and CareFirst.

Experimental/Investigational means services that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. Experimental/Investigational services do not include Controlled Clinical Trials.

FDA means the United States Food and Drug Administration.

Family Caregiver means a relative by blood, marriage, or Adoption who lives with or is the primary Caregiver of the terminally ill Member.

Family Counseling means counseling given to the Immediate Family or Family Caregiver of the terminally ill Member for the purpose of learning to care for the Member and to adjust to the impending death of the Member.

Generic Drug means any Prescription Drug approved by the FDA that has the same bio-equivalency as a specific Brand Name Drug.

Group means the Subscribers' employer or other organization to which CareFirst has issued the Group Contract and the Evidence of Coverage.

Group Contract means the contract, including all duly authorized attachments, notices, amendments and riders, between the Group and CareFirst.

Group Contract Effective Date means the effective date of the Group Contract.

Habilitative means the process of educating or training persons with a disadvantage or disability caused by a medical condition or injury to improve their ability to function in society, where such ability did not exist, or was severely limited, prior to the Habilitative education or training.

Hearing Aid for a Minor Child means 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 or Home Health Care Services means the continued care and treatment of a Member in the home by a licensed Home Health Agency if:

A. The institutionalization of the Member in a hospital or related institution, or Skilled Nursing Facility would otherwise have been required if Home Health Care Services were not provided; and,

B. The Plan of Treatment covering the Home Health Care Service is established and approved in writing by the health care provider, and determined to be Medically Necessary by CareFirst.

Home Health Care Visits mean:

A. Each visit by a member of a Home Health Care team is considered one (1) Home Health Care Visit; and,

B. Up to four (4) hours of Home Health Care Service is considered one (1) Home Health Care Visit.

Hospital-Based Physician means a Non-Preferred Provider who is:

A. A physician licensed in the State of Maryland who is under contract to provide health care services to patients at a hospital; or

B. A group physician practice that includes physicians licensed in the State of Maryland that is under contract to provide health care services to patients at a hospital.

Immediate Family means the Spouse, parents, siblings, grandparents, and children of the terminally ill Member.

Limiting Age means the maximum age up to which a Dependent Child may be covered as stated in the Eligibility Schedule.

Low Vision means a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in Low Vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with Low Vision.

Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.

Mastectomy means the surgical removal of all or part of a breast.

Medical Child Support Order (MCSO) means an order issued in the format prescribed by federal or state law and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An order means a judgment, decree, or a ruling (including approval of a settlement agreement) that:

A. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia; and

B. Creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage; or establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

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

A. In accordance with generally accepted standards of medical practice;

B. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a Member's illness, injury or disease;

C. Not primarily for the convenience of a Member or health care provider; and

D. Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that Member'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.

Medically Necessary Contact Lenses means contact lenses that are determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the

following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism.

Medical Nutrition Therapy means services provided by a licensed dietitian-nutritionist and 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. The licensed dietitian-nutritionist, working in a coordinated, multidisciplinary team effort with the primary care physician, takes into account a Member's condition, food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

Member means an eligible employee or eligible individual who is enrolled under this Evidence of Coverage either as a Subscriber or a Dependent, and for whom the premiums have been received by CareFirst.

Morbid Obesity means a:

A. Body Mass Index that is greater than forty (40) kilograms per meter squared; or

B. Body Mass Index equal to or greater than thirty-five (35) kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

Multiple Project Assurance Contract means a contract between an institution and the United States 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.

NIH means the National Institutes of Health.

Non-Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are rendered when acting within the scope of such license; and, who does not have an agreement with the Vision Care Designee for the rendering of Covered Vision Services. A Non-Contracting Vision Provider may or may not have contracted with CareFirst. The Member should contact the Vision Care Designee for the current list of Contracting Vision Providers.

Non-Participating Dentist means any Dentist who, at the time of rendering a Covered Dental Service to a Member, does not have a written agreement with CareFirst, or CareFirst's designee, for the rendering of such service.

Non-Physician Specialist means a health care provider who is:

A. Not a physician;

B. Licensed or certified under the Health Occupations Article of the Annotated Code of Maryland or the applicable licensing laws of any state or the District of Columbia; and

C. Certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider.

Non-Preferred Dentist means any Dentist who is not a Preferred Dentist, including a Participating Dentist or a Non-Participating Dentist.

Non-Preferred Provider means a health care provider that does not contract with CareFirst to provide Covered Services. Neither Participating Dentists or Non-Participating Dentists who provide Covered Dental Services nor Non-Contracting Vision Providers who provide Covered Vision Services are Non-Preferred Providers for the purposes of this definition.

On-Call Physician means a Non-Preferred Provider who is a physician and who:

A. Has privileges at a hospital;

B. Is required to respond within an agreed upon time period to provide health care services for unassigned patients at the request of a hospital or hospital emergency department; and

C. Is not a Hospital-Based Physician.

Out-of-Pocket Maximum means the maximum amount, as defined and calculated in the Schedule of Benefits, that the Member will have to pay for his/her share of benefits in any Benefit Period.

Outpatient Rehabilitative Services means occupational therapy, speech therapy and physical therapy provided to Members not admitted to a hospital or related institution.

Over-the-Counter means 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, non-prescription eye wear, family planning and contraception items for men, 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 related over-the-counter medications, solutions, items or supplies.

Participating Dentist means any Dentist who, at the time of rendering a Covered Dental Service to a Member, has a written agreement with CareFirst, or CareFirst's designee, for the rendering of such service.

Personal Care means a service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation. Personal Care includes:

A. Help in walking;

B. Help in getting in and out of bed;

C. Help in bathing;

D. Help in dressing;

E. Help in feeding; and

F. General supervision and help in daily living.

Pharmacist means an individual licensed to practice pharmacy regardless of the location where the activities of practice are performed.

Pharmacy means an establishment in which prescription or nonprescription drugs or devices are compounded, dispensed, or distributed.

Plan of Treatment means 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 Brand Name Drug means a Brand Name Drug that is included on CareFirst's Preferred Drug List.

Preferred Dentist means one of a network of Participating Dentists who, at the time of rendering a Covered Dental Service to a Member, has a written agreement with CareFirst, or CareFirst's designee, for the rendering of such service. Preferred Dentist relates only to method of payment, and does not imply that any Dentist is more or less qualified than another. The fact that a Dentist is a Participating Dentist does not guarantee that the Dentist is a Preferred Dentist.

Preferred Drug List means the list of Brand Name Drugs and Generic Drugs issued by CareFirst and used by health care providers when writing, and Pharmacists, when filling, prescriptions. All Generic Drugs are included in the Preferred Drug List. Not all Brand Name Drugs are included in the Preferred Drug List. CareFirst may change this list periodically without notice to Members. A copy of the Preferred Drug List is available to the Member upon request.

Preferred Generic Drug means a Generic Drug on the CareFirst Preferred Drug List used for the treatment of diabetes, high cholesterol, high blood pressure (hypertension), depression or asthma.

Preferred Preventive Drug means a Prescription Drug or Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is included on the CareFirst Preferred Preventive Drug List.

Preferred Preventive Drug List means the list issued by CareFirst of Prescription Drugs or Over-the-Counter medications or supplies dispensed under a written prescription by a health care provider that have been identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration.

CareFirst may change this list periodically without notice to Members. A copy of the Preferred Preventive Drug List is available to the Member upon request.

Preferred Provider means a health care provider that has contracted with CareFirst to render Covered Services to Members. A Preferred Dentist who provides Covered Dental Services or a Contracting Vision Provider who provides Covered Vision Services is not a Preferred Provider for the purposes of this definition. Preferred Provider relates only to method of payment, and does not imply that any physician, health care professional or health care facility is more or less qualified than another.

Prescription Drug means

- **A. A drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;"**
- **B. 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;**
- **C. A covered Over-the-Counter medication or supply; or,**
- **D. Any Diabetic Supply.**

Prior Authorization List means the limited list of Prescription Drugs issued by CareFirst for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from CareFirst. A copy of the Prior Authorization List is available to the Member upon request.

Professional Nutritional Counseling means individualized advice and guidance given to a Member who is at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness or condition, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a licensed dietitian-nutritionist, physician, physician assistant, or nurse practitioner.

Qualified Home Health Agency means a licensed program approved for participation as a home health agency under Medicare, or certified as a home health agency by the Joint Commission on Accreditation of Healthcare Organizations, its successor, or the applicable state regulatory agency.

Qualified Hospice Care Program means a coordinated, interdisciplinary program provided by a hospital, Qualified Home Health Agency, or other health care facility that is licensed or certified by the

state in which it operates as a hospice program and is designed to meet the special physical, psychological, spiritual, and social needs of terminally ill Members and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement period. Benefits are available to:

A. Members who have no reasonable prospect of cure as estimated by a physician; and

B. The Immediate Families or Family Caregivers of those Members.

Qualified Medical Support Order (QMSO) means a Medical Child Support Order, issued under state law or the laws of the District of Columbia, that is issued to an employer sponsored health plan that complies with section 609(A) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Rescind or Rescission means a termination, cancellation or discontinuance of coverage that has 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. Coverage is not Rescinded and a cancellation or discontinuance of coverage is not a Rescission if:

A. The termination, cancellation or discontinuance of coverage has only a prospective effect; or

B. The termination, cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due, by the Group.

Respite Care means temporary care provided to the terminally ill Member to relieve the Caregiver/Family Caregiver from the daily care of the Member.

Service Area means the 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, except for emergency services. CareFirst may amend the defined Service Area at any time by notifying the Subscriber in writing.

The Service Area is as follows: the District of Columbia; the state of Maryland; in the Commonwealth of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince William Counties in Virginia lying east of Route 123.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that is accredited or approved under Medicare or The Joint Commission and provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care, or rehabilitation services. Inpatient skilled nursing is for patients who are medically fragile with limited endurance and require a licensed health care professional to provide skilled services in order to ensure the safety of the patient and to achieve the medically desired result. Inpatient skilled nursing services must be provided on a 24 hour basis, 7 days a week.

Sound Natural Teeth means teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) that are in good condition; absent decay, fracture, bone loss, periodontal disease, root canal pathology or root canal therapy and excludes any tooth replaced by artificial means (implants, fixed or removable bridges, dentures).

Special Enrollment Period means a period during which an eligible individual who experiences certain qualifying events may enroll in, or change enrollment in, under this Evidence of Coverage outside of any Annual Open Enrollment Periods.

Specialist means a licensed health care provider who is certified or trained in a specified field of medicine.

Specialty Drugs means high-cost injectables, infused, oral or inhaled Prescription Drugs for the ongoing treatment of a chronic condition, including but not limited to, the following: *HEMOPHILIA, HEPATITIS C, MULTIPLE SCLEROSIS, INFERTILITY TREATMENT MANAGEMENT, RHEUMATOID ARTHRITIS, PSORIASIS, CROHN'S DISEASE, CANCER (ORAL MEDICATIONS), AND GROWTH HORMONES*. These Prescription Drugs usually require specialized handling (such as refrigeration).

Spouse means an eligible individual who is legally married to the Subscriber under the laws of the state or jurisdiction in which the marriage was performed.

Subscriber means a Member who is enrolled as an eligible employee or eligible former eligible employee rather than as a Dependent.

Surgical Assistant means a provider who assists a physician during an operative procedure. The assistant may be a medical doctor, podiatrist, oral surgeon, physician assistant, nurse midwife, nurse practitioner, or registered nurse first assistant.

Team Surgery means when two or more surgeons of the same or different specialties are required to perform separate portions of the same surgical procedure at the same time.

Urgent Care means 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 freestanding facility that is not a physician's office and which provides Urgent Care.

Vision Care Designee means the entity with which CareFirst has contracted to administer Covered Vision Services. CareFirst's Vision Care Designee is Davis Vision, Inc.

Waiting Period means the period of time, stated in the Eligibility Schedule, that must pass before an eligible employee or any Dependent is eligible for coverage under the terms of the Group Contract.

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage.

A. A Subscriber must meet the eligibility requirements stated in the Eligibility Schedule.

B. Any other Member must be a Dependent of a Subscriber and meet the eligibility requirements stated in this Evidence of Coverage. The eligibility of Dependents to enroll is stated in the Eligibility Schedule.

C. For each Subscriber and Member, CareFirst must receive premium payments as required by the Group Contract.

2.2 Eligibility of Subscriber's Spouse. If the Group has elected to include coverage for the Subscriber's Spouse, then a Subscriber may enroll a Spouse as a Dependent. Except for a divorced spouse covered under a continuation of coverage provision under a previous group policy, a Subscriber cannot cover a former spouse once divorced or if the marriage had been annulled. Premium changes resulting from the enrollment of a Spouse will be effective as of the Effective Date of the Spouse's enrollment.

2.3 Eligibility of Children. If the Group has elected to include coverage for Dependent Children of the Subscriber or a Subscriber's covered Spouse, then a Subscriber may enroll one or more Dependent Children. A Dependent Child means an eligible individual who:

A. Is:

1. The natural child, stepchild, or adopted child of the Subscriber or the Subscriber's covered Spouse;

2. A child (including a grandchild) placed with the Subscriber or the Subscriber's covered Spouse for legal Adoption;

3. A child under testamentary or court appointed guardianship, other than temporary guardianship for less than twelve (12) months duration, of the Subscriber or the Subscriber's covered Spouse; or

4. A grandchild of the Subscriber or the Subscriber's covered Spouse who:

a) Is unmarried; and

b) Is a dependent of the Subscriber or the Subscriber's covered Spouse as that term is used in 26 U.S.C. §§ 104, 105 and 106; and

B. Is under the Limiting Age as stated in the Eligibility Schedule; or

C. Is a disabled Dependent Child who is older than the Limiting Age and the Subscriber provides proof that: (1) the Dependent Child is incapable of self-support or maintenance because of a mental or physical incapacity; (2) that the Dependent Child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse for support and maintenance; and (3) that the Dependent Child had been covered under the Subscriber's or the Subscriber's Spouse's prior health insurance coverage since before the onset of the mental or physical incapacity.

D. Is the subject of a Medical Child Support Order (MCSO) or Qualified Medical Support Order (QMSO) that creates or recognizes the right of the child to receive benefits under the health insurance coverage of the Subscriber or the Subscriber's covered Spouse.

E. A child whose relationship to the Subscriber is not listed above, including foster children or children whose only relationship is one of temporary legal guardianship (except as provided above), is not eligible to enroll and is not covered, even though the child may live with the Subscriber and be dependent upon him or her for support.

2.4 Limiting Age for Covered Dependent Children.

A. All covered Dependent Children are eligible for coverage up to the Limiting Age for Dependent Children stated in the Eligibility Schedule.

B. A Dependent Child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if, at the time coverage would otherwise terminate::

1. The Dependent Child is incapable of self-support or maintenance because of mental or physical incapacity;

2. The Dependent Child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse for support and maintenance;

3. The mental or physical incapacity occurred before the covered Dependent Child reached the Limiting Age specified in the Eligibility Schedule; and

4. The Subscriber provides CareFirst with proof of the Dependent Child's a mental or physical incapacity within thirty-one (31) days after the Dependent Child reaches the Limiting Age for Dependent Children. CareFirst has the right to verify whether the child is and continues to qualify as an incapacitated Dependent Child.

C. Dependents' coverage will automatically terminate if there is a change in their age, status, or relationship to the Subscriber, such that they no longer meet the eligibility requirements of this Evidence of Coverage or the Eligibility Schedule. Coverage of an ineligible Dependent will terminate as stated in the Eligibility Schedule.

2.5 Open Enrollment Opportunities. An eligible individual may elect coverage for himself or herself as a Subscriber or for an eligible Dependent only during the following times and under the following conditions.

A. Annual Open Enrollment. During an Annual Open Enrollment Period, an eligible individual may enroll as a Subscriber or Member.

B. Newly Eligible Employees. If an eligible individual is a new employee or a newly eligible employee of the Group, the eligible individual may enroll him or herself and any eligible Dependent during the time period specified in the Eligibility Schedule.

C. Newly Eligible Dependent Children. If the Group has elected to include coverage for the Subscriber's Dependent Children under this Evidence of Coverage, then a Subscriber may add a newly eligible Dependent Child to this Evidence of Coverage outside the Annual Open Enrollment Period as described below. Other than the categories of Dependent Children listed below, eligible Dependent Children can only be added to this Evidence of Coverage during the Group's Annual Open Enrollment Period or a Special Enrollment Period, except as stated under the Medical Child Support Orders section of this Evidence of Coverage. Enrollment will be effective as stated in the Eligibility Schedule.

1. The Effective Date for a Dependent Child is the Dependent Child's First Eligibility Date. First Eligibility Date means

a) For a newborn Dependent Child, the child's date of birth.

b) For a newly adopted Dependent Child, the earlier of:

(1) A judicial decree of Adoption; or

(2) Placement of the child in the Subscriber's home as the legally recognized proposed adoptive parent.

c) For an eligible grandchild or stepchild (non-newborn), the date the grandchild or stepchild became a dependent of the Subscriber or the Subscriber's Spouse.

d) For a Dependent Child for whom guardianship has been granted by court or testamentary appointment, the date of the appointment.

2. The Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the First Eligibility Date. Coverage for a newly eligible Dependent Child shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

3. <u>The Subscriber must enroll such a Dependent Child within thirty-one (31) days of the child's First Eligibility Date when an additional premium is due for the enrollment of the Dependent Child. Otherwise, the Dependent Child will not be covered and cannot be enrolled until the next Annual Open Enrollment Period. Coverage beyond thirty-one (31) days may cost an additional premium. An additional premium will be due unless there are three (3) or more Dependent Children under the age of twenty-one (21) already enrolled by the Subscriber.</u> .

D. Special Enrollment. If an eligible individual does not enroll during an Annual Open Enrollment Period or the enrollment period for a newly eligible employee or newly eligible Dependent, he or she may only enroll during a Special Enrollment Period.

2.6 <u>Special Enrollment Period</u>. Special enrollment is allowed for certain eligible individuals who lose coverage. Special enrollment is also allowed with respect to certain Dependent beneficiaries. If only the Subscriber is eligible under this Evidence of Coverage and Dependents are not eligible to enroll, the Special Enrollment Periods for a Spouse or Dependent child are not applicable.

A. Special enrollment for certain individuals who lose coverage:

1. CareFirst will permit current employees and Dependents described in paragraph 2.6A.2 of this section to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage if the conditions described in paragraph 2.6A.3 are satisfied.

2. Individuals eligible for special enrollment.

a) When employee loses coverage. A current employee and any Dependents (including the employee's Spouse) each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:

(1) The employee and the Dependents are otherwise eligible to enroll;

(2) When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(3) The employee satisfies the conditions of paragraph 2.6A.3.a), b), or c) of this section, and if applicable, paragraph 2.6A.3.d) of this section.

For purposes of this paragraph 2.6A.2.a), an employee is covered under the other employer sponsored plan or group health benefits plan and lost coverage as a result of a proceeding in a case under title 11, commencing after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time. In the case of an event described in this paragraph 2.6A.2.a), "lost coverage" includes a substantial elimination of coverage with respect to a qualified beneficiary as described in 29 U.S.C. § 1167(3)(c) within one year before or after the date of the commencement of the proceeding.

b) When Dependent loses coverage.

(1) A Dependent of a current employee (including the employee's Spouse) and the employee each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:

(a) The Dependent and the employee are otherwise eligible to enroll;

(b) When coverage was previously offered, the Dependent had coverage under any group health plan or health insurance coverage; and

(c) The Dependent satisfies the conditions of paragraph 2.6A.3.a), b), or c) of this section, and if applicable, paragraph 2.6A.3.d) of this section.

(2) However, CareFirst is not required to enroll any other Dependent unless the Dependent satisfies the criteria of paragraph 2.6A.2.b), or the employee satisfies the criteria of paragraph 2.6A.2.a).

3. Conditions for special enrollment.

a) Loss of eligibility for coverage. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of paragraph 2.6A.3 are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under paragraph 2.6A.3 does not include a loss due to the failure of the employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under paragraph 2.6A.3 includes, but is not limited to:

(1) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing (including a covered employee becoming eligible for benefits under Title XVIII of the Social Security Act);

(2) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(3) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual;

(4) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(5) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that include that individual.

b) Termination of employer contributions. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of paragraph 2.6A.3.b) are satisfied at the time employer contributions towards the employee's or Dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.

c) Exhaustion of COBRA continuation coverage. In the case of an employee or Dependent who has coverage that is COBRA continuation coverage, the conditions of paragraph 2.6A.3.c) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of paragraph 2.6A.3.c), an individual who satisfies the conditions for special enrollment of paragraph 2.6A.3.c) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of paragraph 2.6A.3.c).

d) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any Dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any Dependent of the employee under paragraph 2.6A.3.d). The Group and CareFirst must treat an employee as having satisfied the requirement permitted under paragraph 2.6A.3.d) if the employee provides a written statement that coverage was being declined because the employee or Dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement than to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)

B. Special enrollment with respect to certain Dependent beneficiaries:

1. CareFirst will permit the individuals described in paragraph 2.6B.2 of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage. Paragraph 2.6C of this section describes the required special enrollment period.

2. Individuals eligible for special enrollment. An individual is described in paragraph 2.6B.2 if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph 2.6B.2.a), b), c), d), e), or f) of this section.

a) Current employee only. A current employee is described in paragraph 2.6B.2.a) if the current employee acquires a new Dependent through marriage, birth, Adoption, or placement for Adoption.

b) Spouse of a participant only. Provided the Group provides coverage for Dependents, an individual is described in paragraph 2.6B.2.b) if either:

(1) The individual becomes the Spouse of a participant; or

(2) The individual is a Spouse of a participant and a child becomes a Dependent of the participant through birth, Adoption, or placement for Adoption.

c) Current employee and Spouse. A current employee and, provided the Group provides coverage for Dependents, an individual who is or becomes a Spouse of such an employee, are described in paragraph 2.6B.2.c) if either:

(1) The employee and the Spouse become married; or

(2) The employee and Spouse are married and a child becomes a Dependent of the employee through birth, Adoption, or placement for Adoption.

d) Dependent of a participant only. Provided the Group provides coverage for Dependents, an individual is described in paragraph 2.6B.2.d) if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, Adoption, or placement for Adoption.

e) Current employee and a new Dependent. A current employee and, provided the Group provides coverage for Dependents, an individual who is a Dependent of the employee, are described in paragraph 2.6B.2.e) if the individual becomes a Dependent of the employee through marriage, birth, Adoption, or placement for Adoption.

f) Current employee, Spouse, and a new Dependent. A current employee, and provided the Group provides coverage for Dependents, the employee's Spouse and the employee's Dependent are described in paragraph 2.6B.2.f) if the Dependent becomes a Dependent of the employee through marriage, birth, Adoption, or placement for Adoption.

C. Applying for special enrollment and effective date of coverage.

1. If a Subscriber enrolls within 31 days of any event described in paragraph 2.6A.3 or paragraph 2.6B.2 of this section, the Subscriber and his or her Dependents will

be treated as timely enrolled. In the event of a loss of eligibility of coverage due to the operation of a lifetime limit on all benefits, the Subscriber and his or her Dependents will be treated as timely enrolled if the Subscriber enrolls within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.

2. Timely enrollment under paragraph 2.6C will be effective as stated in the Eligibility Schedule.

D. Special Enrollment Regarding Medicaid Termination or CHIP Eligibility.

1. CareFirst will permit an employee or Dependent who is eligible for coverage, but not enrolled, to enroll for coverage under the terms of this paragraph D if either of the following conditions is met:

a) The employee or Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a state child health plan under title XXI of such Act and coverage of the employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage; or

b) The employee or Dependent becomes eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a state child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

2. Notification Requirement.

a) The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or Dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act.

b) The employee must notify the Group, and the Group must notify CareFirst, no later than sixty (60) days after the date the employee or Dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, Medicaid, or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

3. Effective Date of Coverage. If the employee or Dependent is eligible to enroll for coverage under this Evidence of Coverage pursuant to this paragraph D of this section and the timely notification has been given by the employee as provided in paragraph 2.6D.2, then coverage will be effective as stated in the Eligibility Schedule.

E. Special Enrollment Under Maryland Law.

1. An eligible employee or Dependent is eligible for special enrollment under this section if an eligible employee or Dependent loses minimum essential coverage.

2. Loss of minimum essential coverage under paragraph 2.6E.1 of this section does not include loss of coverage due to:

a) Failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage; or

b) A rescission under 45 C.F.R. 147.128.

3. The special enrollment period for an eligible employee or Dependent who meets the requirement for a triggering event under paragraph 2.6E.1 of this section shall be for thirty (30) days, beginning on the date of the triggering event.

2.7 Child Support Orders (MCSO or QMSO).

A. Eligibility.

1. Upon receipt of an MCSO or QMSO, when coverage of the Subscriber's family members is available under this Evidence of Coverage, CareFirst will accept enrollment of a Dependent Child that is the subject of an MCSO or QMSO and the eligible employee parent of such child without regard to enrollment period restrictions, within the time period prescribed by law. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any state or the District of Columbia. Coverage will be effective as of the effective date of the order, and the premium will be adjusted as needed. However, if the Subscriber has not completed any applicable Waiting Periods for coverage, the child subject to the MCSO/QMSO will not be enrolled, and coverage will not be effective, until the end of the Waiting Period.

The Subscriber must be enrolled under this Group Contract in order for the child to be enrolled. If the Subscriber is not enrolled when CareFirst receives the MCSO/QMSO, CareFirst will enroll both the Subscriber and the child, without regard to enrollment period restrictions.

2. Enrollment for such a child will not be denied because the child:

a) Was born out of wedlock;

b) Is not claimed as a dependent on the Subscriber's federal tax return;

c) Does not reside with the Subscriber; or

d) Is covered under any Medical Assistance or Medicaid program.

3. Coverage required by an MCSO or QMSO will be effective as of the date of the order.

4. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to an MCSO or QMSO may not be terminated unless written evidence is provided to CareFirst stating:

a) The MCSO or QMSO is no longer in effect;

b) The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage;

c) The Group has eliminated family members' coverage for all its employees; or

d) The employer no longer employs the insuring parent, except if the parent elects to exercise the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the Group's plan for postemployment health

insurance coverage for Dependents.

B. Administration. When the child subject to an MCSO or QMSO does not reside with the Subscriber, CareFirst will:

1. Send to the non-insuring custodial parent the identification cards, claims forms, the applicable Evidence of Coverage and any information needed to obtain benefits;

2. Allow the non-insuring custodial parent or a provider of a Covered Service, Covered Dental Service or Covered Vision Service to submit a claim without the approval of the Subscriber; and

3. Provide benefits directly to:

a) The non-insuring parent;

b) The provider of the Covered Services, Covered Dental Services or Covered Vision Services; or

c) The appropriate child support enforcement agency of any state or the District of Columbia.

2.8 Effective Dates. Coverage will be effective as stated in the Eligibility Schedule.

2.9 Clerical or Administrative Error. If an individual is ineligible for coverage, the individual cannot become eligible just because CareFirst or the Group made a clerical or administrative error in recording or reporting information. Likewise, if a Member is eligible for coverage, the Member will not lose coverage because CareFirst or the Group made an administrative or clerical error in recording or reporting information.

2.10 Cooperation and Submission of Information. CareFirst may require verification from the Group and/or Subscriber pertaining to the eligibility of a Subscriber or Dependent enrolled hereunder. The Group and/or Subscriber agree to cooperate with and assist CareFirst, including providing CareFirst with reasonable access to Group records upon request. At any time that coverage under this Evidence of Coverage is in effect, CareFirst reserves the right to request documentation substantiating eligibility as described in this Evidence of Coverage and to provide any information it receives regarding a Member's eligibility to the Group.

Knowingly attempting to obtain, or actually obtaining, eligibility for any person known to the Subscriber to be ineligible pursuant to the eligibility provisions stated in this Evidence of Coverage, shall constitute an act or practice constituting fraud or an intentional misrepresentation of material fact and in addition to the remedies related to Rescission provided in this Evidence of Coverage, CareFirst reserves to itself any and all rights provided by law for such act or acts.

2.11 Proof of Eligibility. CareFirst retains the right to require proof of relationships or facts to establish eligibility. CareFirst will pay the reasonable cost of providing such proof.

SECTION 3
TERMINATION OF COVERAGE

3.1 Disenrollment of Individual Members.
Coverage of individual Members will terminate on the date stated in the Eligibility Schedule for the following reasons.

A. CareFirst may terminate a Member's coverage as follows.

1. Nonpayment of any premium contribution that is required by the Group. Coverage ends on the date stated in CareFirst's written notice of termination.

2. The Member no longer meets the conditions of eligibility.

3. Subject to the Contestability of Coverage provision in the Group Contract, CareFirst can terminate a Member's coverage with thirty (30) days prior written notice as provided in Section 3.4 if CareFirst determines that the Member:

a) Made an intentional misrepresentation of information that is material to the acceptance of the enrollment form. The Member represents that all information contained in the Member's enrollment form is true, correct and complete to the best of his or her knowledge and belief.

b) The Member or the Member's representative made fraudulent misstatements related to coverage or benefits.

B. The Group is required to terminate the Subscriber's coverage and the coverage of the Dependents if the Subscriber is no longer employed by the Group or the Subscriber no longer meets the Group's eligibility requirements for coverage.

C. The Group is required to notify the Subscriber if a Member's coverage is cancelled. If the Group does not notify the Subscriber, this will not continue the Member's coverage beyond the termination date of coverage. The Member's coverage will terminate on the termination date stated in the Eligibility Schedule.

D. Coverage for the Subscriber and Dependents will terminate if the Subscriber cancels coverage through the Group or changes to another health benefits plan offered by the Group.

E. Except in the case of a Dependent Child enrolled pursuant to a Medical Child Support Order or Qualified Medical Support Order, the Dependent's coverage will terminate if the Subscriber terminates the Dependent's enrollment as provided under Section 3.2.

F. Coverage for Dependents will automatically terminate if they no longer meet the eligibility requirements of the Group Contract because of a change in age, status or relationship to the Subscriber. Coverage of an ineligible Dependent will terminate on the termination date stated in the Eligibility Schedule.

G. The Subscriber is responsible for notifying CareFirst (through the Group) of any changes in the status of Dependents that affect their eligibility for coverage. These changes include a divorce. If the Subscriber does not notify CareFirst of these types of changes and it is later determined that a Dependent was not eligible for coverage, CareFirst has the right to recover these amounts from the Subscriber or from the Dependent, at CareFirst's option, net of any Premiums attributable to the Dependent's enrollment paid during the period of the Dependent's ineligibility.

3.2. Termination of Enrollment by the Subscriber Due to Qualifying Events.

A. If certain life events occur and subject to the limitations of Section 3.6, a Subscriber may be able to make a mid-year change to reduce and/or terminate the coverage of the Subscriber or Dependent. The following is a list of qualifying life events that allow the Subscriber to reduce or terminate coverage. The changes in coverage must satisfy the consistency requirements as described below.

1. Qualifying Life Events:

a) Legal marital status. A change in a Member's legal marital status, including marriage, divorce, death of spouse, a legal separation or an annulment.

b) Employment status. A change in a Subscriber's, Spouse's or Dependent's employment status due to termination or commencement of employment, a strike or lockout, an unpaid leave of absence, or a change in worksite.

c) Dependent status. A change in status of a Dependent that results in the Dependent's eligibility or ineligibility for coverage because of age or similar circumstances.

d) Any reduction or termination that a Subscriber makes must be consistent with the life event. The life event must affect eligibility for coverage under the plan or under a plan of the spouse or Dependent, which covers the spouse or Dependent as a Subscriber. The change in coverage must correspond with the life event.

B. Under certain circumstances, a Subscriber may make mid-year reduction or termination to coverage for reasons, such as coverage cost or Medicare eligibility as described below.

1. Coverage Events:

a) If there is reduction or elimination of coverage during the Benefit Period.

b) If the Spouse's plan allows a Subscriber and Dependents to make an enrollment change during that plan's annual open enrollment period, the Subscriber may make a corresponding mid-year change.

2. Cost Events: If the cost of coverage increases or decreases significantly during a Benefit Period (including a Subscriber's change from part-time to full-time work or vice versa) and the Group does not offer a similar, but less costly, coverage option.

3. Entitlement to Medicare. If a Subscriber, Spouse or Dependent becomes eligible for Medicare mid-year, a Subscriber, Spouse or Dependent may (but is not required) terminate coverage.

C. If the Subscriber or Dependent terminates for reasons described in Section 3.2A. and 3.2B., the effective date of termination shall be 11:59 p.m. on the last day of the month in which the Subscriber or Dependent requested the termination of coverage.

3.3 **Effect of Termination. Upon termination of the coverage of a Member, all benefits for the Member under the Group Contract will end on the effective date of termination, except in the case of: (i) a Member who is entitled to, and elects, continued coverage under Section 4.1; or (ii) a Member who is entitled to an extension of benefits under Sections 4.2, 4.3 or 4.4, in which case benefits will end on the last day of the Member's extension of benefits or continued eligibility period, as applicable.**

3.4 **Rescission of Individual Enrollment for Fraud or Misrepresentation. Coverage of a Member will be Rescinded if:**

A. The Member has performed an act, practice, or omission that constitutes fraud;

B. The Member has made an intentional misrepresentation of material fact; or

C. An act, practice or omission that constitutes fraud includes, but is not limited to, fraudulent use of CareFirst's identification card by the Member, the alteration or sale of prescriptions by the Member, or an attempt by a Subscriber to enroll non-eligible persons.

CareFirst will provide thirty (30) days advance written notice of any Rescission. CareFirst shall have the burden of persuasion that its Rescission complies with applicable state law. The Rescission shall either (i) void the enrollment of the Member as of the Member's Effective Date (for fraudulent acts, practices, or omissions that occur at the time of enrollment); or (ii) in all other cases, void the enrollment of the Member as of the first date that the Member performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of material fact.

3.5 **Death of a Subscriber. In the event of the Subscriber's death, coverage of any Dependents may continue under the Subscriber's enrollment as stated in Section 4 of this Evidence of Coverage. The effective date of termination of the Subscriber's enrollment and, if applicable, the enrollment of any Dependents will be as stated in the Eligibility Schedule.**

3.6 **Medical Child Support Orders or Qualified Medical Support Orders. Unless coverage is Rescinded or terminated for non-payment of the premium, a Subscriber who has enrolled a Dependent Child subject to an MCSO/QMSO may not terminate his or her enrollment or the enrollment of such a child unless written evidence is provided to CareFirst that:**

A. The MCSO/QMSO is no longer in effect;

B. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage;

C. The Group has eliminated family member coverage for all Members; or

D. The Group no longer employs the Subscriber, except if the Subscriber elects continuation coverage under applicable state or federal law the child will continue in this post-employment coverage.

3.7 **Termination of Evidence of Coverage upon Termination of Group Contract. This Evidence of Coverage, and the enrollment of the Member(s), will terminate automatically upon the effective date of the termination of the Group Contract by the Group or CareFirst for any reason.**

3.8 **No Reinstatement. Upon termination, enrollment will not reinstate automatically under any circumstances.**

SECTION 4
CONTINUATION OF COVERAGE

4.1 Continuation of Eligibility upon Loss of Group Coverage.

A. Federal Continuation of Coverage under COBRA. If the Group health benefit plan provided under this Evidence of Coverage is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended from time to time, and a Member's coverage terminates due to a "Qualifying Event" as described under COBRA, continuation of participation in this Group health benefit plan may be possible. The employer offering this Group health benefit plan is the plan administrator. It is the plan administrator's responsibility to notify a Member concerning terms, conditions and rights under COBRA. If a Member has any questions regarding COBRA, the Member should contact the plan administrator.

B. Uniformed Services Employment and Reemployment Rights Act (USERRA). USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers, and insurers, from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

If an eligible employee leaves his or her job to perform military service, the eligible employee has the right to elect to continue his or her Group coverage including any Dependents for up to twenty-four (24) months while in the military. Even if continuation of coverage was not elected during the eligible employee's military service, the eligible employee has the right to be reinstated in their Group coverage when re-employed, without any Waiting Periods or pre-existing condition exclusion periods except for service connected illnesses or injuries. If an eligible employee has any questions regarding USERRA, the eligible employee should contact the plan administrator. The plan administrator determines eligible employees and provides that information to CareFirst.

C. Maryland Continuation of Coverage. Under Maryland law, applicable changes in status for a Member to qualify for continuation of coverage are: death of the Subscriber; divorce of the Subscriber and Spouse; or voluntary or involuntary termination of the Subscriber's employment (other than for cause).

1. State Continuation for Spouse and Children as a Result of the Death of the Subscriber.

This provision applies in the event of the death of a Subscriber who was a resident of Maryland and who was covered under the Group Contract or predecessor Group Contract with the same employer for at least three (3) months prior to the death of the Subscriber. This provision also applies to a newborn child of the deceased Subscriber born to the surviving Spouse after the date of the Subscriber's death. Continuation of coverage under this provision shall be provided without evidence of insurability or additional Waiting Periods.

a) Continuation coverage that is elected by or on behalf of a Dependent under the Group Contract shall begin on the date of the death of the Subscriber and end on the earliest of the following:

(1) Eighteen (18) months after the date of the death of the Subscriber;

(2) The date on which the Dependent fails to make timely premium payment for this continuation coverage;

(3) The date on which the Dependent becomes eligible for hospital, medical, or surgical benefits under an insured or self-insured group health benefit program or plan, other than the Group Contract, that is written on an expense-incurred basis or is with a health maintenance organization;

(4) The date on which the Dependent becomes entitled to benefits under Medicare;

(5) The date on which the Dependent accepts hospital, medical, or surgical coverage under a non-group contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;

(6) The date on which the Dependent elects to terminate coverage under the Group Contract;

(7) The date on which the employer ceases to provide benefits to its employees under a group contract; or

(8) With regard to the coverage of a Dependent Child, the date on which the Dependent Child would no longer have been covered under the Group Contract if the Subscriber's death had not occurred.

b) The election period to continue coverage under this provision begins on the date of the death of the Subscriber and expires forty-five (45) days after that date. To elect continuation of coverage under this provision, the Dependent or authorized representative must submit a signed election form to the Group within the election period.

c) To continue coverage under this provision, the Dependent shall pay to the Group:

(1) The sum of the employer contribution and any contribution that the insured would have been required to pay if the insured had not died; and

(2) A reasonable administrative fee, not to exceed 2% of the premium.

The payment of the amount specified above may be paid in monthly installments if the Dependent elects to do so.

2. State Continuation for Spouse and Children in the Event of Divorce. This provision applies in the event of the divorce of a Subscriber who is a resident of Maryland and whose coverage included one (1) or more Dependents at the time of divorce. This provision also applies to a newborn child of the Subscriber born to the former Spouse after the date of divorce.

a) When this provision applies, Dependents of the Subscriber may continue to be covered under the Group Contract until the earliest of any of the following:

(1) The date of termination of the Subscriber's coverage under the Group Contract;

(2) The date on which there is a failure to make timely payment for

this continuation coverage;

(3) The date the Dependent enrolls in other group or non-group coverage;

(4) The date on which the Dependent becomes entitled to benefits under Medicare;

(5) With regard to the coverage of a Spouse, the last day of the month in which the Spouse remarries;

(6) With regard to the coverage of a Dependent Child, the date on which the Dependent Child would no longer have been covered under the Group Contract if the Subscriber's divorce had not occurred, for example if the child attains the Limiting Age;

(7) The effective date of an election by the Dependent to no longer be covered under the Group Contract; or,

(8) The date on which the Group ceases to provide benefits to its employees under a group contract;

b) To receive this continued coverage, the Subscriber or the divorced Spouse must notify the Group of the divorce no later than:

(1) Sixty (60) days following the divorce if, on the date of the divorce, the Subscriber is covered under the Group Contract or another group health plan offered by the Group; or

(2) Thirty (30) days following the effective date of the Subscriber's coverage if, on the date of the divorce, the Subscriber was covered under a group health plan offered through a different employer.

c) The Subscriber or the former Spouse of the Subscriber shall pay to the Group the full cost of the continuation coverage.

3. State Continuation for Subscriber and Dependents in the Event of Voluntary or Involuntary Termination of Employment for Any Reason Other Than Cause. This provision applies in the event of the voluntary and involuntary termination of employment of a Subscriber who is a resident of Maryland, who was voluntarily or involuntarily terminated from employment for any reason other than cause and who was covered under the Group Contract or predecessor group contract with the same employer for at least three (3) months prior to the termination of employment.

a) When this provision applies, the Subscriber and any Dependent who was covered under the Subscriber on the date of termination may elect to remain covered under the Group Contract until the earliest of any of the following:

(1) Eighteen (18) months after the date of termination of the Subscriber's employment;

(2) Failure to make timely payment for this continuation coverage;

(3) Enrollment in other group or non-group coverage;

(4) The date on which the Subscriber becomes entitled to benefits

under Medicare;

(5) The effective date of an election by the Subscriber to no longer be covered under the Group Contract; or

(6) The date on which the employer ceases to provide benefits to its employees under a group contract.

(7) With regard to the coverage of a Dependent Child, the date on which the Dependent Child would no longer have been covered under the Group Contract if the Subscriber's employment had not terminated, for example if the child attains the Limiting Age; or the date on which the Group ceases to provide benefits to its employees under the Group Contract.

b) This continuation coverage must be elected, through submission of a signed election notification form to the Group, within forty-five (45) days after termination of the Subscriber's employment. The Subscriber is responsible for payment through the Group of the full cost of this continuation coverage that may include a reasonable administrative fee not to exceed 2% of the Premium, which is payable to and retained by the Group. No evidence of insurability is required.

4.2 Extension of Benefits - Covered Services.

A. If a Member is Totally Disabled when his/her coverage terminated, CareFirst shall continue to pay benefits for Covered Services in effect at the time the Member's coverage terminates, for expenses incurred by the Member for the condition causing the disability until the earlier of:

1. The date the Member ceases to be Totally Disabled; or

2. Twelve (12) months after the date coverage terminates.

Totally Disabled means the Member's inability, due to a condition of physical or mental incapacity, to engage in the duties or activities of a person of the same age and sex in reasonably good health. CareFirst reserves the right to verify whether the Member is and continues to be Totally Disabled.

CareFirst may, at any time, require the Member to provide proof of Total Disability.

B. During an extension period required under this section, a premium may not be charged.

C. This section does not apply if:

1. Coverage is terminated because the Subscriber or the Member fails to pay a required premium;

2. Coverage is terminated for fraud or material misrepresentation by the Subscriber or the Member; or

3. Any coverage provided by a succeeding health benefit plan:

a) Is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit required under this section; and

b) Does not result in an interruption of benefits.

4.3 Extension of Benefits - Covered Dental Services.

A. If a Member is eligible to receive Covered Dental Services, CareFirst shall provide Covered Dental Services, in accordance with the Evidence of Coverage in effect at the time the Member's coverage terminates, for a course of treatment for at least ninety (90) days after the date coverage terminates if the treatment:

1. Begins before the date coverage terminates; and

2. Requires two or more visits on separate days to a Dentist's office (this provision does not apply to orthodontic services).

B. CareFirst shall provide covered benefits for covered orthodontic services, as defined in the attached Description of Covered Services and the attached Schedule of Benefits, for a Member whose coverage terminates:

1. For sixty (60) days after the date the Member's coverage terminates if the orthodontist has agreed to or is receiving monthly payments; or

2. Until the later of sixty (60) days after the date the Member's coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

C. During an extension period required under this section a premium may not be charged.

D. This section does not apply if:

1. Coverage is terminated because the Subscriber or the Member fails to pay a required premium;

2. Coverage is terminated for fraud or material misrepresentation by the Subscriber or the Member; or

3. Any coverage provided by a succeeding health benefit plan:

a) Is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit required under this section; and

b) Does not result in an interruption of benefits.

4.4 **<u>Extension of Benefits - Covered Vision Services</u>. If a Member s eligible to receive Covered Vision Services and has ordered frames and spectacle lenses or contact lenses before the date the Member's coverage terminates, the Vision Care Designee will provide benefits for the frames and spectacle lenses or contact lenses if the Member receives the frames and spectacle lenses or contact lenses within thirty (30) days after the date of the order. During an extension period required under this section a premium may not be charged.**

This section does not apply if:

A. **Coverage is terminated because the Subscriber or the Member fails to pay a required premium;**

B. **Coverage is terminated for fraud or material misrepresentation by the Subscriber or the Member; or**

C. **The Member obtained uninterrupted and comparable coverage under a succeeding health benefit plan that is less than the cost to the Member of the extended benefit.**

5.1 Coordination of Benefits (COB).

A. Applicability.

1. This Coordination of Benefits (COB) provision applies to this CareFirst Plan when a Member has health care coverage under more than one Plan.

2. If this COB provision applies, the order of benefit determination rules should be reviewed first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:

a) Shall not be reduced when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan; and

b) May be reduced when, under the order of determination rules, another Plan determines its benefits first. The reduction is explained in Section 5.1D.2.

B. Definitions.
For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions section of this Evidence of Coverage.

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments, that is covered in whole or in part by any of the Plans covering the Member. This means that any expense or portion of an expense that is not covered by any of the Plans is not an Allowable Expense. If this CareFirst Plan is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst Plan means this Evidence of Coverage.

Intensive Care Policy means a health insurance policy that provides benefits only when treatment is received in that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy, including those of nonprofit health service Plan and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law or coverage under a governmental Plan, except a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

1. An individually underwritten and issued, guaranteed renewable, specified disease policy;

2. An intensive care policy, which does not provide benefits on an expense incurred basis;

3. Coverage regulated by a motor vehicle reparation law;

4. The first one-hundred dollars ($100) per day of a hospital indemnity contract;

5. An elementary and/or secondary school insurance program sponsored by a school or school system; or

6. Personal Injury Protection (PIP) benefits under a motor vehicle liability insurance policy.

Primary Plan or Secondary Plan means the order of benefit determination rules stating whether this CareFirst Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

1. When this CareFirst Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

2. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

3. When there are more than two Plans covering the Member, this CareFirst Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Specified Disease Policy means a health insurance policy that provides (1) benefits only for a disease or diseases specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

C. Order of Benefit Determination Rules.

1. General.
When there is a basis for a claim under this CareFirst Plan and another Plan, this CareFirst Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless;

a) The other Plan has rules coordinating benefits with those of this CareFirst Plan; and

b) Both those rules and this CareFirst Plan's rules require that this CareFirst Plan's benefits be determined before those of the other Plan.

2. Rules.
This CareFirst Plan determines its order of benefits using the first of the following rules which applies:

a) Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(1) Secondary to the Plan covering the person as a dependent, and

(2) Primary to the Plan covering the person as other than a dependent (e.g., retired employee),

Then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

b) Dependent child covered by more than one Plan. Unless there is a court decree stating otherwise, when this CareFirst Plan and another Plan cover the same child as a dependent, the order of benefits shall be determined as follows:

(1) For a dependent child whose parents are married or are living together:

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

(b) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

(2) For a dependent child whose parents are separated, divorced, or are not living together:

(a) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but the parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph does not apply with respect to any claim for services rendered before the entity has actual knowledge of the terms of the court decree.

The rule described in (1) above also shall apply if: i) a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, or ii) a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child.

(b) If there is no court decree setting out the responsibility for the child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:

i) The Plan of the parent with custody of the child;

ii) The Plan of the spouse of the parent with the custody of the child;

iii) The Plan of the parent not having custody of the

child; and then

iv) The Plan of the spouse of the parent who does not have custody of the child.

(3) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules stated in (1) and (2) of this paragraph as if those individuals were parents of the child.

c) Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as an employee who is neither laid off nor retired or a person covered as a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

d) Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefits determination:

(1) First, the benefits of a Plan covering the person as an employee, retiree, member or subscriber (or as that person's dependent);

(2) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

e) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

D. Effect on the Benefits of this CareFirst Plan.

1. When this Section Applies.
This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

2. Reduction in this CareFirst Plan's Benefits.
When this CareFirst Plan is the Secondary Plan, the benefits under this CareFirst Plan may be reduced so that the total benefits that would be payable or provided by all the other Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. If the benefits of this CareFirst Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this CareFirst Plan.

E. Right to Receive and Release Needed Information.
Certain facts are needed to apply these COB rules. CareFirst has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst need not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst Plan must give this CareFirst Plan any facts it needs to pay the claim.

F. Facility of Payment.
A payment made under another Plan may include an amount that should have been paid under this CareFirst Plan. If it does, this CareFirst Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this CareFirst Plan. This CareFirst Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery.
If the amount of the payments made by this CareFirst Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;

2. Insurance companies; or

3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

5.2 <u>Medicare Eligibility</u>.
This provision applies to Members who are entitled to Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of sixty-five (65) or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in the Evidence of Coverage. Benefits that are covered by Medicare are subject to the provisions in this section.

A. Coverage Secondary to Medicare.
Except where prohibited by law, the benefits under this CareFirst Plan are secondary to Medicare.

B. Medicare as Primary.

1. When benefits for Covered Services, Covered Dental Services or Covered Vision Services are paid by Medicare as primary, this CareFirst Plan will not duplicate those payments. CareFirst will coordinate and pay benefits based on Medicare's payment (or the payment Medicare would have paid). When CareFirst coordinates the benefits with Medicare, CareFirst's payments will be based on the Medicare allowance (if the provider is a participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare), less any claim reduction or denial due to a Member's failure to comply with Medicare's administrative requirements. CareFirst's right to coordinate is not contingent on any payment actually being made on the claim by Medicare. Members enrolled in Medicare agree to, and shall, complete and submit to Medicare, CareFirst, and/or any health care providers all claims, consents, releases, assignments and other documents required to obtain or assure such claim payment by Medicare.

2. If a Medicare-eligible Member has not enrolled in Medicare Part A and/or Part B, CareFirst will not "carve-out," reduce, or reject a claim based on the amount Medicare would have paid had the Member actually applied for, claimed, or received Medicare benefits.

5.3 Employer or Governmental Benefits.
Coverage does not include the cost of services or payment for services for any illness, injury, or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or

B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

5.4 Subrogation.
CareFirst has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. This right applies to the amount of benefits paid by CareFirst for injuries or illnesses where a third party could be liable.

Recovery means to be successful in a lawsuit, to collect or obtain an amount; to obtain a favorable or final judgment; to obtain an amount in any legal manner; an amount finally collected or the amount of judgment as a result of an action brought against a third-party or involving uninsured or underinsured motorist claims. A Recovery does not include payments made to the Member under the Member's personal injury protection policy. CareFirst will not recover medical expenses from a Subscriber unless the Subscriber or Member recovers for medical expenses in a cause of action or settlement.

A. The Member shall notify CareFirst as soon as reasonably possible that a third-party may be liable for the injuries or illnesses for which benefits are being provided or paid.

B. To the extent that actual payments made by CareFirst result from the occurrence that gave rise to the cause of action, CareFirst shall be subrogated and succeed to any right of recovery of the Member against any person or organization.

C. The Member shall pay CareFirst the amount recovered by suit, settlement, or otherwise from any third-party's insurer, any uninsured or underinsured motorist coverage, or as permitted by law, to the extent that any actual payments made by CareFirst result from the occurrence that gave rise to the cause of action.

D. The Member shall furnish information and assistance, and execute papers that CareFirst may require to facilitate enforcement of these rights. The Member shall not commit any action prejudicing the rights and interests of CareFirst.

E. In a subrogation claim arising out of a claim for personal injury, the amount recovered by CareFirst may be reduced by:

1. Dividing the total amount of the personal injury recovery into the total amount of the attorney's fees incurred by the injured person for services rendered in connection with the injured person's claim; and

2. Multiplying the result by the amount of CareFirst's subrogation claim. This percentage may not exceed one-third (1/3) of CareFirst's subrogation claim.

F. On written request by CareFirst, a Member or Member's attorney who demands a reduction of the subrogation claim shall provide CareFirst with a certification by the Member that states the amount of the attorney's fees incurred.

G. These provisions do not apply to residents of the Commonwealth of Virginia.

6.1 Entire Certificate; Changes. The entire Evidence of Coverage includes: (a) this Evidence of Coverage; (b) Benefit Determination and Appeal and Grievance Procedures; (c) the Description of Covered Services; (d) Schedule of Benefits; (e) Eligibility Schedule; and (f) any additional duly authorized notices, amendments and riders.

No amendment or modification of any term or provision of this Evidence of Coverage is effective unless authorized in writing by an executive officer of CareFirst. Any duly authorized notice, amendment or rider will be issued by CareFirst to be attached to the Evidence of Coverage. Any waiver of an Evidence of Coverage term or provision shall only be given effect for its stated purpose and shall not constitute or imply any subsequent waiver.

Oral statements cannot be relied upon to modify or otherwise affect the benefits, limitations and/or exclusions of this Evidence of Coverage, or increase or void any coverage or reduce any benefits. Such oral statements cannot be used in the prosecution or defense of a claim.

6.2 Claims and Payment of Claims.

A. Claim Forms. A claim form can be requested by calling the Member and Provider Service telephone number on the identification card during regular business hours. CareFirst shall provide claim forms for filing proof of loss to each claimant. If CareFirst does not provide the claim forms within fifteen (15) days after notice of claim is received, the claimant is deemed to have complied with the requirements of the policy as to proof of loss if the claimant submits, within the time fixed in the policy for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

When a Member subject to a Medical Child Support Order or a Qualified Medical Support Order does not reside with the Subscriber, CareFirst will

1. Send the non-insuring, custodial parent identification cards, claims forms, the applicable certificate of coverage or member contract, and any information needed to obtain benefits;

2. Allow the non-insuring, custodial parent or a provider of a Covered Service to submit a claim without the approval of the Subscriber; and

3. Provide benefits directly to:

a) The non-insuring, custodial parent;

b) The provider of the Covered Services; or

c) The appropriate child support enforcement agency of any state or the District of Columbia.

B. Proof of Loss. CareFirst does not require a written notice of claims for services provided by Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers or Contracting Pharmacy Providers.

For Covered Services, Covered Dental Services or Covered Vision Services provided by Non-Preferred Providers, Non-Participating Dentists, Non-Contracting Vision Providers or non-Contracting Pharmacy Providers, Members must furnish written proof of loss, or have the provider submit proof of loss, to CareFirst within ninety (90) days after the date of the loss. Failure to furnish proof within the time required shall not invalidate or

reduce any claim if it was not reasonably possible to give proof within the required time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

CareFirst will honor claims submitted for Covered Services, Covered Dental Services or Covered Vision Services by any agency of the federal, state or local government that has the statutory authority to submit claims beyond the time limits established under this Evidence of Coverage. These claims must be submitted to CareFirst before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst deems necessary to process the claims. CareFirst provides forms for this purpose.

C. Time of Payment of Claims. Benefits payable will be paid not more than thirty (30) days after receipt of written proof of loss. Any accrued benefits unpaid at the Subscriber's death shall be paid to the Subscriber's estate.

D. Claim Payments Made in Error. If CareFirst makes a claim payment to or on behalf of the Member in error, the Member is required to repay CareFirst the amount that was paid in error. If the Member has not repaid the full amount owed CareFirst and CareFirst makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

E. Payment of Claims - Covered Medical Services. Payment for Covered Services rendered by a Preferred Provider will be paid directly to the Preferred Provider rendering the services. Direct payments will also be made by CareFirst to providers from the United States Department of Defense and the United States Department of Veteran Affairs.

If a Member makes an Assignment of Benefits for services rendered by a Non-Preferred Provider who is a physician, a Hospital-Based Physician, an On-Call Physician, or an Ambulance Service Provider, payment for services will be paid directly to the Non-Preferred Provider who is a physician, a Hospital-Based Physician, an On-Call Physician or an Ambulance Service Provider except as provided in Section 6.3C. If a Member receives Covered Services from any other Non-Preferred Provider, CareFirst reserves the right to pay either the Member or the provider. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Preferred Provider. In any event, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and, unless the fee is negotiated, for any Balance Bill except in the case of an On-Call Physician, Hospital-Based Physician or Ambulance Service Provider who accepts an Assignment of Benefits.

F. Payment of Claims - Covered Dental Services. Payments for Covered Dental Services rendered by Preferred or Participating Dentists will be paid directly to Preferred or Participating Dentists or to their representatives.

If a Member makes an Assignment of Benefits for services rendered by a Non-Participating Dentist who is a physician, payment for services will be paid directly to the Non-Participating Dentist who is a physician, except as provided in Section 6.3C. If a Member receives Covered Dental Services from any other Non-Participating Dentist, CareFirst reserves the right to pay either the Member or the provider. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Participating Dentist. In any event, the Member is responsible for any applicable Deductible or Coinsurance amounts stated in the Schedule of Benefits and for any Balance Bill.

G. Payment of Claims - Covered Vision Services. Billing and reimbursement will be handled by the Vision Care Designee for Covered Vision Services. Payments for Covered Vision Services rendered by Contracting Vision Providers will be paid directly to the

Contracting Vision Provider or to the provider's representative by the Vision Care Designee.

If a Member makes an Assignment of Benefits for services rendered by a Non-Contracting Vision Provider who is a physician, payment for services will be paid directly to the Non-Contracting Vision Provider who is a physician, except as provided in Section 6.3C. If a Member receives Covered Vision Services from any other Non-Contracting Vision Provider, the Vision Care Designee reserves the right to pay either the Member or the provider. It is the Member's responsibility to apply any Vision Care Designee payments received to the claim from the Non-Contracting Vision Provider. In any event, the Member is responsible for any Balance Bill.

H. Payment of Claims - Covered Prescription Drugs. If the Member purchases a covered Prescription Drug from a Contracting Pharmacy Provider, the benefit payment is made directly to the Contracting Pharmacy Provider and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance. The Member is responsible for any applicable Deductible, Copayment or Coinsurance and the Contracting Pharmacy Provider may bill the Member directly for such amounts.

If the Member purchases a covered Prescription Drug from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance.

I. When a Dependent Child is the subject of a Medical Child Support Order or a Qualified Medical Support Order and the parent who is not the Subscriber incurs covered expenses on the child's behalf, CareFirst reserves the right to make payment for these covered expenses to the non-Subscriber parent, the provider, or the Maryland Department of Health and Mental Hygiene.

6.3 No Assignment. A Member cannot assign any benefits or payments due under this Evidence of Coverage to any person, corporation or other organization, except a Member may:

A. Make an Assignment of Benefits to a physician who is a Non-Preferred Provider, a Non-Participating Dentist, or a Non-Contracting Vision Provider, or to an On-Call Physician, a Hospital Based Physician or an Ambulance Service Provider who accepts an Assignment of Benefits;

B. Assign any other benefits or payments under the Evidence of Coverage only as specifically provided by this Evidence of Coverage or required by law; or

C. Notwithstanding any permitted and valid Assignment of Benefits, CareFirst or the Vision Care Designee may refuse to directly reimburse the Non-Preferred Provider, Non-Participating Dentist, Non-Contracting Vision Provider, On-Call Physician, Hospital Based Physician or Ambulance Service Provider if:

1. CareFirst or the Vision Care Designee receives notice of the Assignment of Benefits after the time that it has paid the benefits to the Member;

2. CareFirst or the Vision Care Designee, due to an inadvertent administrative error, has previously paid the Member;

3. The Member withdraws the Assignment of Benefits before CareFirst or the Vision Care Designee has paid the Non-Preferred Provider, Non-Participating Dentist, Non-Contracting Vision Provider, On-Call Physician, Hospital Based Physician or Ambulance Service Provider; or

4. **The Member paid the Non-Preferred Provider, Non-Participating Dentist, Non-Contracting Vision Provider, On-Call Physician, Hospital Based Physician or Ambulance Service Provider the full amount due at the time of service.**

6.4 **Legal Actions. A Member cannot bring any lawsuit against CareFirst to recover under this Evidence of Coverage before the expiration of sixty (60) days after written proof of loss has been furnished, and not after three (3) years from the date that written proof of loss is required to be submitted to CareFirst.**

6.5 **Events Outside of CareFirst's Control. If CareFirst, for any reason beyond the control of CareFirst, is unable to provide the coverage promised, CareFirst is liable for reimbursement of the expenses necessarily incurred by any Member in procuring the services through other providers, to the extent prescribed by the Insurance Commissioner of Maryland.**

6.6 **Identification Card.**
Any cards issued to Members are for identification only.

A. **Possession of an identification card confers no right to benefits.**

B. **To be entitled to such benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable premiums have actually been paid.**

C. **Any person receiving benefits to which he or she is not then entitled will be liable for the actual cost of such benefits.**

6.7 **Member Medical Records. It may be necessary to obtain Member medical records and information from hospitals, Skilled Nursing Facilities, physicians or other practitioners who treat the Member. When a Member becomes covered, the Member (and, if the Member is legally incapable of giving such consent, the representative of such Member) automatically gives CareFirst permission to obtain and use such records and information, including medical records and information requested to assist CareFirst in determining benefits and eligibility of Members.**

6.8 **Physical Examinations. CareFirst has the right to examine a Member when and as often as it may reasonably require during the pending of a claim under this Evidence of Coverage. Any examination required by CareFirst will be performed at the expense of CareFirst.**

6.9 **Confidentiality. CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable financial, medical or health-related data. In that regard, CareFirst will not provide to the Group or unauthorized third parties any personally identifiable financial or medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.**

6.10 **CareFirst's Relationship to Providers. Health care providers, including Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers, are independent contractors or organizations and are related to CareFirst by contract only. Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers are not employees or agents of CareFirst and are not authorized to act on behalf of or obligate CareFirst with regard to interpretation of the terms of this Evidence of Coverage, including eligibility of Members for coverage or entitlement to benefits. Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers maintain a provider-patient relationship with the Member and are solely responsible for the professional services they provide. CareFirst is not responsible for any acts or omissions, including those involving malpractice or wrongful death of Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, Contracting Pharmacy Providers, or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.**

6.11 **Provider and Services Information. Listings of current Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers and Contracting Pharmacies will be made available to Group members at the time of enrollment. Updated listings are available to the Group and to Members upon request. The listing of Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers and Contracting Pharmacies is updated every fifteen (15) days on the CareFirst website, www.carefirst.com.**

6.12 **Administration of Evidence of Coverage. CareFirst may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Evidence of Coverage.**

6.13 **Rights to Vest in Guarantor. In the event of insolvency, CareFirst's rights under the Group Contract (including, but not limited to, all rights to premiums to the extent permitted by applicable bankruptcy law) will become vested in any person or entity that guarantees payment and actually pays for the services and benefits that CareFirst is obligated to make available under the Group Contract.**

6.14 **CareFirst's Relationship to the Group. The Group is not CareFirst's agent or representative and is not liable for any acts or omissions by CareFirst or any provider. CareFirst is not an agent or representative of the Group and is not liable for any acts or omissions of the Group.**

6.15 **Delivery of Evidence of Coverage. Unless CareFirst makes delivery directly to the Subscriber, CareFirst will provide to the Group, for delivery to each Subscriber, a statement that summarizes the essential features of the coverage and states to whom benefits under the Evidence of Coverage are payable. Only one (1) statement will be issued for each family unit, except in the instance of an eligible child who is covered due to an MCSO/QMSO. In that instance, an additional Evidence of Coverage will be delivered to the custodial parent, upon request.**

6.16 **Evidence of Coverage Binding on Members. The Evidence of Coverage can be amended, modified or terminated in accordance with any provision of the Evidence of Coverage or by mutual agreement between CareFirst and the Group without the consent or concurrence of Members. By electing coverage under this Evidence of Coverage, or accepting benefits under this Evidence of Coverage, Members are subject to all terms, conditions and provisions of the Group Contract and Evidence of Coverage.**

6.17 **Payment of Contributions. The Group Contract is issued to the Group on a contributory basis in accordance with the Group's policies. The Group has agreed to collect from Members any contributory portion of the premium and pay to CareFirst the premium as specified in the Group Contract for all Members.**

6.18 **Rights under Federal Laws. The Group may be subject to federal law (including the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and/or the Affordable Care Act) that relates to the health benefits provided under this Group Contract. For the purposes of ERISA and/or COBRA, the Group is the "plan administrator." As the plan administrator, it is the Group's responsibility to provide Members with certain information, including access to and copies of plan documents describing Member's benefits and rights to coverage under the Group health plan. Such rights include the right to continue coverage upon the occurrence of certain "Qualifying Events."**

In any event, the Member should check with the Group to determine the Member's rights under ERISA, COBRA, HIPAA and/or the Affordable Care Act, as applicable.

6.19 **Representations and not Warranties. All statements made by the Subscriber shall be deemed to be representations and not warranties. No statement made for the purpose of obtaining coverage shall void such coverage or reduce benefits unless contained in a written instrument signed by the Subscriber, a copy of which has been furnished to CareFirst.**

6.20 **Rules for Determining Dates and Times. The following rules will be used when determining dates and times:**

A. **All dates and times of day will be based on the dates and times applicable to the Washington, DC area, i.e., Eastern Standard Time or Eastern Daylight Saving Time, as applicable.**

B. **When reference is made to coverage being effective on a particular date, this means 12:01 a.m. on that date.**

C. **When reference is made to termination being effective on a particular date, this means 12:00 midnight on that date.**

D. **"Days" mean calendar days, including weekends, holidays, etc., unless otherwise noted.**

E. **"Year" refers to Calendar Year, unless a different benefit year basis is specifically stated.**

6.21 **Notices.**

A. **To the Member. Notice to Members will be sent via electronic mail, if the Member has consented to receive such notices via electronic mail, or by first class mail to the most recent address or electronic address for the Member in CareFirst's files. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst, of an address change. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice.**

B. **To CareFirst. When notice is sent to CareFirst, it must be sent by first class mail to:**

Group Hospitalization and Medical Services, Inc.
840 First Street, NE
Washington, DC 20065

1. **Notice will be effective on the date of receipt by CareFirst, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the United States Postal Service.**

2. **CareFirst may change the address at which notice is to be given by giving written notice thereof to the Subscriber.**

6.22 **Amendment Procedure. Amendments must be consistent with state law.**

Regardless of when the amendment is received, this Evidence of Coverage is considered to be automatically amended on the date specified in the contract amendment or the notice of the amendment to the Group (if not stated in the contract amendment), unless otherwise mandated to conform with any applicable changes to state or federal law.

No agent or other person, except an officer of CareFirst, has the authority to waive any conditions or restrictions of the Evidence of Coverage or to bind CareFirst by making any promise or representation or by giving or receiving any information. No change in the Evidence of Coverage will be binding on CareFirst, unless evidenced by an amendment signed by an authorized representative of CareFirst.

6.23 **Complaints about CareFirst. Members may complain to the Maryland Insurance Administration about the operation of CareFirst. Such complaints would include matters other than coverage decisions or adverse decisions as described in Attachment A, Benefit**

Determination and Appeal and Grievance Procedures attached to this Evidence of Coverage. To complain about the operation of CareFirst, Members should contact:

Maryland Insurance Administration
Life and Health Complaints
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Tel: 410-468-2244
Toll Free: 1-800-492-6116
Fax: 410-468-2260
Website: http://www.mdinsurance.state.md.us

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT A

BENEFIT DETERMINATION AND APPEAL AND GRIEVANCE PROCEDURES

This attachment contains certain terms that have a specific meaning as used herein. These terms are capitalized and defined in Section A below, and/or in the Evidence of Coverage to which this document is attached.

These procedures replace all prior procedures issued by the Plan, which afford Members recourse pertaining to denials and reductions of claims for benefits by the Plan.

These procedures only apply to Claims for Benefits. Notification required by these procedures will only be sent when a Member requests a benefit or files a claim in accordance with the Plan's procedures.

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A. DEFINITIONS

The following terms shall have the meaning ascribed to such terms whenever such terms are used in these Claims Procedures.

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Adverse Decision means a utilization review determination that:

1. A proposed or delivered health care service covered under the Member's contract is or was not Medically Necessary, appropriate, or efficient; and

2. May result in non-coverage of the health care service. Adverse Decision does not include a Coverage Decision.

Appeal means a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan under its internal appeal process regarding a Coverage Decision.

Appeal Decision means final determination by the Plan that arises from an Appeal.

Claim for Benefits means a request for a Plan benefit or benefits made by a Member in accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

Claim Involving Urgent Care means any claim for medical care or treatment that involves an Emergency Case or a Urgent Medical Condition. Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Member's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

Claims Procedures means, collectively, the procedures governing the filing of benefit claims, Notification of benefit determinations, and Grievances and Appeals of Adverse Benefit Determinations for Members.

Compelling Reason means a showing that the potential delay in receipt of a health care service until after the Member, the Member's Representative or Health Care provider acting on behalf of the Member exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the Member remaining seriously mentally ill with symptoms that cause the Member to be in danger to self or others.

Complaint means a protest filed with the Maryland Insurance Commissioner involving an Adverse Benefit Determination, Appeal Decision or Grievance Decision.

Coverage Decision means:

1. An initial determination by the Plan or the Plan's Designee that results in non-coverage of a health care service;

2. An determination by the Plan that that an individual is not eligible for coverage under the Evidence of Coverage; or

3. A determination by the Plan that results in the Rescission of an individual's coverage under the Evidence of Coverage;

A Coverage Decision includes nonpayment of all or part of a Claim for Benefits. A Coverage Decision does not include an Adverse Decision or a Pharmacy Inquiry.

Designee of the Commissioner means any person to whom the Commissioner has delegated the authority to review and decide Complaints, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

Emergency Case means medical services are necessary to treat a condition or illness that, without immediate medical attention, would either (i) seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, or (ii) cause the Member to be in danger to self or others.

Filing Date means the earlier of:

1. 5 days after the date of mailing; or

2. The date of receipt.

Grievance means a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member through the Plan's internal Grievance process regarding an Adverse Decision.

Grievance Decision means a final determination by the Plan that arises from a Grievance.

Group Health Plan means an employee welfare benefit Plan within the meaning of Section 3(1) of the Act to the extent that such Plan provides "medical care" within the meaning of Section 733(a) of the Employee Retirement and Income Security Act ("ERISA" or "Act").

Health Advocacy Unit means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article, Annotated Code of Maryland.

Health Care Provider, as used in this attachment, means:

1. An individual who is licensed under the Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the Member; or

2. A hospital as defined in Title 19 Subtitle 3 of the Health-General Article.

Member, as used in this attachment, means an individual entitled to receive health care benefits under this Evidence of Coverage.

Member's Representative means an individual who has been authorized by a Member to file a Grievance, Appeal or a Complaint on behalf of a Member.

Notice or Notification means the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

Pharmacy Inquiry means an inquiry submitted by a pharmacist or pharmacy on behalf of a Member to the Plan, Plan Designee or pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under the Plan.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst e is the carrier under the Evidence of Coverage.

Plan Designee, for purposes of these Claims Procedures, means CareFirst.

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim.

Pre-Service Claim means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Relevant. A document, record, or other information shall be considered Relevant to a Member's claim if such document, record, or other information:

1. Was relied upon in making the benefit determination;

2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

3. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or

4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions towards the cost of coverage.

Urgent Medical Condition means a condition that satisfies either of the following:

1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:

    a. Placing the member's life or health in serious jeopardy;

    b. The inability of the member to regain maximum function;

    c. Serious impairment to bodily function;

    d. Serious dysfunction of any bodily organ or part; or

    e. The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or

2. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

B. SCOPE

The Plan's Claims Procedures were developed in accordance with Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims For Benefits by Members.

C. CLAIMS PROCEDURES

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeals and Grievances of Adverse Benefit Determinations (hereinafter collectively referred to as Claims Procedures) for Members.

These Claims Procedures do not preclude a Member's Representative or Health Care Provider acting on behalf of a Member from acting on behalf of such Member in pursuing a Claim for Benefits, Grievance or Appeal of an Adverse Benefit Determination, or a Complaint to the Maryland Insurance Commissioner. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member.

These Claims Procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations and Adverse Benefit Determinations are made in accordance with governing Plan documents and, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Members.

D. CLAIMS PROCEDURES COMPLIANCE

1. Failure to follow Pre-Service Claims Procedures. In the case of a failure by a Member or a Member's Representative to follow the Plan's procedures for filing a Pre-Service Claim the Member or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This Notification shall be provided to the Member, the Member's Representative, or Health Care Provider acting on behalf of the Member, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member.

   The above shall apply only in the case of a failure that:

   a. Is a communication by a Member, the Member's Representative, or Health Care Provider acting on behalf of the Member that is received by the person or organizational unit designated by the Plan or Plan Designee that handles Claims for Benefits; and

   b. Is a communication that names a specific Member; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

2. Civil Action. A Member is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA.

E. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

1. In general. Except as provided in paragraph E.2 below, if a claim is wholly or partially denied, the Member shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim (for example, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or the claim is not clean and the specific information necessary for the claim to be considered a clean claim).

If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Member prior to the termination of the initial 30-day period. In no event shall such extension exceed a period of 30 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.

2. The Member shall be notified of the determination in accordance with the following, as appropriate.

   a. Expedited Notification of benefit determinations relating to Claims Involving Urgent Care. In the case of a Claim Involving Urgent Care, the Member shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim unless the Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Member shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Member shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Member shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

      i. Receipt of the specified information, or

      ii. The end of the period afforded the Member to provide the specified additional information.

   b. Concurrent care decisions. If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:

      i. Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Member shall be notified in accordance with paragraph E.2.e herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

      ii. Any request by a Member to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Member shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and an Appeal shall be governed by paragraphs G.2, G.3 and G.4 herein as appropriate.

      iii. If a health care service for a Member has been preauthorized or approved by the Plan or the Plan's Designee, the Plan may not deny reimbursement to the Health Care Provider for the preauthorized or approved service delivered to the Member unless:

         1) The information submitted regarding the service was fraudulent or intentionally misrepresentative;

2) Critical information required by the Plan or the Plan's Designee was omitted such that the Plan or Plan Designee's determination would have been different had it known the critical information;

3) A planned course of treatment for the Member was not substantially followed by the Health Care Provider; or

4) On the date the preauthorized service was delivered:

a) the Member was not covered by the Plan;

b) the Plan or the Plan's Designee maintained an automated eligibility verification system that was available to the Provider by telephone or via the Internet; and

c) according to the verification system, the Claimant was not covered by the Plan.

iv. Continued coverage will be provided pending the outcome of an appeal.

c. Other claims for health care benefits. In the case of a claim that is not an urgent care claim or a concurrent care decision the Member shall be notified of the benefit determination in accordance with the below "Pre-Service Claims" or "Post-Service Claims," as appropriate.

i. Pre-Service Claims. In the case of a Pre-Service Claim, the Member shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control, and notifies the Member, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph G. herein.

Authorization of Pre-Service Claims. The Plan or the Plan's Designee will determine whether to authorize or certify a Pre-Service Claim within 2 working days following receipt of all necessary information. If information is needed to make a decision which was not included in the initial request for authorization or certification, the Plan or the Plan's Designee will notify the Health Care Provider within 3 calendar days of the initial request that additional information is needed.

ii. Post-Service Claims. In the case of a Post-Service Claim, the Member shall be notified, in accordance with paragraph G. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary and notifies the Member, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary, the Plan or the Plan's Designee will send a Notice of receipt and status of the claim that states the legitimacy of the claim or the appropriate amount of

reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim. The Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

d. Rescission determinations. The Plan shall provide 30-days advance written Notice of any proposed Rescission of coverage for any individual.

e. Calculating time periods. For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2 above due to a Member's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information.

F. MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

1. This section sets forth the manner and content of Notifications by the Plan of Adverse Benefit Determinations.

2. In the case of an Adverse Decision, the Plan or the Plan's Designee shall send a Member, the Member's Representative or Health Care Provider acting on behalf of the Member written or electronic Notification of any Adverse Benefit Determination. In the case of an Adverse Decision relating a Claim for Benefits that is not a Claim Involving Urgent Care, the Plan or the Plan's Designee shall send the written or electronic Notification within 5 working days after the Adverse Decision has been made. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider:

   a. The identity of the claim involved (including the date of service, the Health Care Provider and the claim amount (if applicable)).

   b. The specific reason or reasons for the Adverse Decision;

   c. Reference to the specific Plan provisions on which the Adverse Decision is based;

   d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

   e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following an Adverse Decision;

   f. The Medical Director's name, business address and business telephone number;

   g. If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision , either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision and that a copy of such rule, guideline, protocol, diagnosis code (and its

corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or

h. If the Adverse Decision is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances.

i. In the case of an Adverse Decision by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

j. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Grievance Decision;

k. That a Complaint may be filed without first filing a Grievance if

i. The Plan notifies the Member in writing that it has waived the requirement that its internal grievance process be exhausted before filing a Complaint with the Commissioner;

ii. The Plan has failed to comply with any of the requirements of the internal grievance procedure described in this attachment; or

iii. the Member, the Member's Representative or Health Care Provider acting on behalf of the Member filing a Grievance on behalf of the Member can demonstrate a Compelling Reason to do so as determined by the Commissioner;

l. The Commissioner's address, telephone number, and facsimile number;

m. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance; and

n. The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

3. In the case of a Coverage Decision, the Plan or the Plan Designee must within 30 calendar days provide Member, Member's Representative and the treating Health Care Provider, a written Notice of the Coverage Decision. The statement must state in detail, in clear, understandable language, the specific factual basis for the Plan's decision and must include the following information:

a. Where applicable, the identity of the claim involved (including the date of service, the Health Care Provider and the claim amount).

b. The specific reason or reasons for the Coverage Decision;

c. Reference to the specific Plan provisions on which the Coverage Decision is based;

d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf

of the Member to perfect the claim and an explanation of why such material or information is necessary;

e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following a Coverage Decision;

f. That the Member, Member's Representative or Health Care Provider acting on behalf of the Member has a right to file an Appeal with the Plan or the Plan's Designee;

g. In the case of a Coverage Decision by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

h. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Appeal Decision;

i. That the Member, Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves a Claim Involving Urgent Care which has not been rendered;

j. The Commissioner's address, telephone number, and facsimile number;

k. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing an Appeal; and

l. The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

4. Adverse Benefit Determinations are made under the direction of the Medical Director.

G. APPEALS AND GRIEVANCES OF ADVERSE BENEFIT DETERMINATIONS

1. To file an Appeal or Grievance of an Adverse Benefit Determination, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member, may contact the Plan at the address and telephone number located on the Member's ID Card; or submit a written request and any supporting record of medical documentation within 180 days of receipt of the written Notification of the Adverse Benefit Determination to the following:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114
410- 581-3000

The Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance or Appeal. See Section K for additional information.

2. a. A Member has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;

b. A Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Member's Claim for Benefits;

c. The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

3. In addition to the requirements of paragraphs G.2.a through c herein, the following apply:

a. The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an individual who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor the subordinate of such individual;

b. In deciding a Grievance of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/Investigational, or not Medically Necessary or appropriate, the Plan or the Plan's Designee shall consult with a Health Care Provider with the same specialty as the treatment under review.

c. Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Member's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

d. Health Care Provider engaged for purposes of a consultation under paragraph H.3.b herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor subordinates of any such individuals; and

e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal or Grievance of an Adverse Benefit Determination may be submitted orally or in writing by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member; and the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its determination in writing within 24 hours of receipt of the expedited request for Appeal or Grievance.

4. Full and fair review. The Plan or the Plan's Designee shall allow a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to review the claim file and to present evidence and written testimony as part of the internal claims and Appeals and Grievances process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:

a. The Plan or the Plan's Designee shall provide the Member, the Member's Representative or Health Care Provider acting on behalf of the Member, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Grievance Decision or Appeal decision is required to be provided under paragraphs H. herein, to give the Member a reasonable opportunity to respond prior to that date; and

b. Before the Plan or the Plan's Designee issues a Grievance Decision or an Appeal Decision based on a new or additional rationale, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Appeal Decision or Grievance Decision is required to be provided under paragraphs H and I. herein, to give the Member, the Member's Representative or Health Care Provider acting on behalf of the Member a reasonable opportunity to respond prior to that date.

H. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (GRIEVANCE DECISIONS)

1. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its benefit determination on review of an Adverse Decision in accordance with the following, as appropriate.

   a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J. herein, of the Grievance Decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the Member's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 24 hours of the orally communicated Grievance Decision.

   b. Pre-service claims. In the case of a Pre-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J herein, of the Grievance Decision within a reasonable period of time appropriate to the medical circumstances. Oral Notification shall be provided not later than 30 days after the filing date of the Member, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.

   c. Post-service claims. In the case of a Post-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with item J herein, of the Grievance Decision within a reasonable period of time. Oral Notification shall be provided not later than 45 working days after the filing date of the Member's, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.

2. If the Plan or the Plan's Designee does not have sufficient information to complete its Grievance Decision, the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within five (5) working days after the Filing Date of the Grievance by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan or the Plan's Designee. The Plan or the Plan's Designee Notification shall:

   a. Notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member that it cannot proceed with reviewing the Grievance unless additional information is provided; and

   b. Assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in gathering the necessary information without further delay.

3. The Plan or the Plan's Designee may extend the 30-day or 45-working day period required for making an Grievance Decision under paragraph H.1.b., c. with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.

4. Calculating time periods. For purposes of Section H. herein, the period of time within which a Grievance Decision shall be made begins at the time a Grievance is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph H.2 herein due to a Member's, the Member's Representative's or Health Care Provider 's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member until the date on which the Member, the Member's Representative or Health Care Provider acting on behalf of the Member responds to the request for additional information.

5. In the case of Grievance, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs G.2, G.3, and G.4 herein as is appropriate.

I. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS)

1. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its Appeal Decision no later than 60 working days after the filing date of the Member, the Member's Representative 's or Health Care Provider's Appeal. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 30 days of the Appeal Decision.

2. The Plan or the Plan's Designee may extend the 60-working day period required for making an Appeal Decision under I.1 with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.

3. Calculating time periods. For purposes of Section I. herein, the 60-working day period within which a benefit determination on review shall be made, subject to any extension granted pursuant to paragraph I.2 above, begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make an Appeal Decision accompanies the filing.

J. MANNER AND CONTENT OF NOTIFICATION OF GRIEVANCE DECISION OR APPEAL DECISION

The Plan or the Plan's Designee shall provide a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with written or electronic Notification after it has provided oral communication of the Grievance Decision or Appeal Decision. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member:

1. The identity of the claim involved (including the date of service, the Health Care Provider and the claim amount (if applicable)).

2. The specific factual basis for the adverse determination;

3. Reference to the specific criteria and standards, including interpretive guidelines, on which the benefit determination is based;

4. A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Member's Claim For Benefits;

5. A statement describing any voluntary Appeal or Grievance procedures offered by the Plan and the Member's right to obtain the information about such procedures, and a statement of the Member's right to bring an action under Section 502(a) of the Act; and

6. a. If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination, either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, diagnosis code (and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or

   b. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

   c. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available it so contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

7. In the case of a Grievance involving an Adverse Decision, a statement that includes the following information:

   a. The name, business address and business telephone number of the Medical Director who made the decision;

   b. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Grievance Decision;

   c. The Commissioner's address, telephone number, and facsimile number;

d. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

e. The Health Advocacy Unit's address, telephone number, facsimile number and electronic mailing address;

f. The Employee Benefit Security Administration's telephone number and website address; and

g. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

8. In the case of an Appeal involving a Coverage Decision, a statement that includes the following information:

a. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Appeal Decision; and

b. The Commissioner's address, telephone number, and facsimile number;

c. The Employee Benefit Security Administration's telephone number and website address; and

d. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

e. The Health Advocacy Unit's address, telephone number, facsimile number and electronic mailing address; and

f. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

9. Grievance Decisions and Appeal Decisions are made under the direction of the Chief Medical Officer:

1501 S. Clinton Street
Baltimore, Maryland 21224
410- 581-3000

K. FILING OF COMPLAINT AFTER RECEIPT OF NOTIFICATION OF GRIEVANCE DECISIONS OR APPEAL DECISIONS

1. Within 4 months after the date of receipt of an Appeal Decision or a Grievance Decision, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner for review of the Grievance Decision or Appeal Decision.

2. A Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint without first exhausting the Plan's internal Grievance or Appeals process if:

a. In the case of an Adverse Decision:

i. The Plan or the Plan's Designee waives the requirement that the internal Grievance process be exhausted before filing a Complaint with the Commissioner;

ii. The Plan or the Plan's Designee has failed to comply with any of the requirements of the internal Grievance process;

iii. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member provides sufficient information and supporting documentation in the Complaint to demonstrate a Compelling Reason.

b. In the case of a Coverage Decision, the Complaint involves an Urgent Medical Condition for which care has not been rendered.

3. The remaining provisions of this paragraph K. apply to Complaints regarding Adverse Decisions and Grievance Decisions.

a. The Commissioner shall notify the Plan or the Plan's Designee of the Complaint within five working days after the date the Complaint is filed with the Commissioner.

b. Except for an Emergency Case (Claim Involving Urgent Care), the Plan or the Plan's Designee shall provide to the Commissioner any information requested by the Commissioner no later than seven working days from the date the Plan or the Plan's Designee receives the request for information.

4. a. Except as provided in paragraph K.4.b below, the Commissioner shall make a final decision on a Complaint:

i. Within 45 days after a Complaint is filed regarding a Pre-Service Claim;

ii. Within 45 days after a Complaint is filed regarding a Post-Service Claim; and

iii. Within 24 hours after a Complaint is filed regarding a Claim Involving Urgent Care.

b. The Commissioner may extend the period within which a final decision is to be made under paragraph.K.4.a. for up to an additional 30 working days if:

i. the Commissioner has not yet received information requested by the Commissioner; and

ii. the information requested is necessary for the Commissioner to render a final decision on the Complaint.

5. The Commissioner shall seek advice from an independent review organization or medical expert for Complaints filed with the Commissioner that involve a question of whether a Pre-Service Claim or a Post-Service Claim is Medically Necessary. The Commissioner shall select an independent review organization or medical expert to advise on the Complaint in the manner set forth in Section 15-10A-05 of the Insurance Article.

6. The Plan or the Plan's Designee shall have the burden of persuasion that its Adverse Decision or Grievance, as applicable, is correct during the review of a Complaint by the Commissioner or Designee of the Commissioner, and in any hearing held regarding the Complaint.

7. As part of the review of a Complaint, the Commissioner or Designee of the Commissioner may consider all of the facts of the case and any other evidence deemed Relevant.

8. Except as provided below, in responding to a Complaint, the Plan or the Plan's Designee may not rely on any basis not stated in its Adverse Benefit Determination.

   a. The Commissioner may allow the Plan or the Plan's Designee, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to provide additional information as may be relevant for the Commissioner to make a final decision on the Complaint.

   b. The Commissioner shall allow the Member, the Member's Representative or Health Care Provider acting on behalf of the Member at least 5 working days to provide the additional information.

   c. The Commissioner's use of additional information may not delay the Commissioner's decision on the Complaint by more than five working days.

9. The Commissioner may request the Member or a legally authorized designee of the Member to sign a consent form authorizing the release of the Member's medical records to the Commissioner or Designee of the Commissioner that are needed in order for the Commissioner to make a final decision on the Complaint.

10. Subject to paragraphs H, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner if the Member, the Member's Representative or Health Care Provider acting on behalf of the Member does not receive the Plan's Grievance Decision within the following timeframes:

    a. Within 30 days after the filing date of a Grievance regarding a Pre-Service Claim;

    b. Within 45 working days after the filing date of a Grievance regarding a Post-Service Claim; and

    c. Within 24 hours after the receipt of a Grievance regarding a Claim Involving Urgent Care.

Note: the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance. Contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
410- 528-1840 or 1-877- 261-8807
Fax: 410- 576-6571
E-mail: heau@oag.state.md.us

L. MEMBER COMMENTS AND QUALITY COMPLAINTS

The Plan provides Members an opportunity to present comments or any other questions or concerns with regard to operations or administration of the Plan, and file a quality complaint regarding the quality of any Plan service. All comments and quality complaints should be addressed to the Member Services Department. In the event that you are dissatisfied with a determination of the Member Services Department, the procedures listed below must be followed.

Inquiries, comments, and complaints concerning the nature of your medical care should also be addressed to the Member Services Department. That department will also assist you in filing a quality complaint after all other avenues of resolution have been exhausted.

A Member may complain to the Department of Health and Mental Hygiene, Office of Licensing and Certification Programs regarding the operation of The Plan. The address and telephone number of the Department is available through our Member Services Department. The Member may also contact the Maryland Insurance Administration at:

Maryland Insurance Administration
Inquiry and Investigation, Life and Health
200 St. Paul Place
Suite 2700
Baltimore, MD 21202-2272
410-468-2244

M. DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEAL PROCESS

If the Plan fails to adhere to the minimum requirements for Claims Procedures relating to Claims for Benefits by Members or Section 15-10A-02 of the Insurance Code, Annotated Code of Maryland, the Member is deemed to have exhausted the internal appeals and grievance processes of paragraph G through J herein. Accordingly the Member may initiate an external review under paragraph K of this section, as applicable. The Member is also entitled, where applicable, to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the Claim for Benefits. If a Member, where applicable, chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the Claim for Benefits, Grievance, or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

N. MISCELLANOUS

The Group reserves the right to change, modify, or terminate the Plan, in whole or in part.

Members have no Plan benefits after a Plan termination or partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial Plan termination affecting them and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state or local law.

Members should not rely on any oral description of the Plan, because the written terms in the Group's Plan documents always govern.

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan

An independent licensee of the Blue Cross and Blue Shield Association.

ATTACHMENT B
DESCRIPTION OF COVERED SERVICES - PREFERRED PROVIDER PLAN

The services described herein are eligible for coverage under the Evidence of Coverage. CareFirst will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services, Covered Dental Services and Covered Vision Services incurred by a Member, including any extension of benefits for which the Member is eligible.

It is important to refer to the Schedule of Benefits to determine the percentage of the Allowed Benefit that CareFirst will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists important information about Deductibles, the Out-of- Pocket Maximum and other features that affect Member coverage, including specific benefit limitations.

Refer to the Evidence of Coverage for additional definitions of capitalized terms included in this Description of Covered Services.

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer

SECTION 1
OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES

1.1 Office Visits. Benefits are available for office visits for diagnosis and treatment of a medical illness or injury, including care and consultation by primary care providers and Specialists.

1.2 Laboratory Tests, X-Ray/Radiology Services and Diagnostic Procedures. Coverage is provided for laboratory tests, x-ray/radiology services and diagnostic procedures.

1.3 Preventive Services. In addition to the benefits listed in this provision, CareFirst will provide benefits for health exams and other services for the prevention and detection of disease, at intervals appropriate to the Member's age, sex, and health status, in accordance with the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended, as well as CareFirst preventive guidelines. At a minimum, benefits for preventive services listed in this provision will be provided once per Benefit Period.

Benefits will be provided for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). This includes benefits for preventive maternity care. CareFirst will update new recommendations to the preventive benefits listed in this provision at the schedule established by the Secretary of Health and Human Services.

Benefits for preventive care include the following:

A. Cancer Screening Services. Benefits are available for the following cancer screening services.

1. Prostate Cancer Screening. Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal exams:

a) For men who are between forty (40) and seventy-five (75) years of age;

b) When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;

c) When used for staging in determining the need for a bone scan for patients with prostate cancer; or,

d) When used for male Members who are at high risk for prostate cancer.

2. Colorectal Cancer Screening. Colorectal cancer screening provided in accordance with the latest guidelines issued by the American Cancer Society.

3. Pap Smears. Benefits are available for pap smears, including tests performed using FDA approved gynecological cytology screening technologies, at intervals appropriate to the Member's age and health status, as determined by CareFirst.

4. Breast Cancer Screening. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. 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 in or around November 2009.

B. Chlamydia Screening Test.

1. Chlamydia Screening Test means any laboratory test that:

a) Specifically detects for infection by one or more agents of chlamydia trachomatis; and

b) Is approved for this purpose by the FDA.

2. Multiple Risk Factors means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

3. Coverage will be provided for an annual routine Chlamydia Screening Test for women who are under the age of 20 years if they are sexually active and 20 years old or older if they have Multiple Risk Factors.

4. Coverage will be provided for an annual routine Chlamydia Screening test for men who have Multiple Risk Factors.

C. Human Papillomavirus Screening Test

1. Coverage is provided for a Human Papillomavirus Screening Test at the screening intervals supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

2. Human Papillomavirus Screening Test means any laboratory test that specifically detects for infection by one or more agents of the human papillomavirus and is approved for this purpose by the FDA.

D. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

A recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered to be:

1. In effect after it has been adopted by the director of the Centers for Disease Control and Prevention; and,

2. For routine use if it is listed on the immunization schedules of the Centers for Disease Control and Prevention.

E. Well Child Care. 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.

F. Women's Preventive Services. With respect to women, to the extent not described in this provision, evidence-informed preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

G. Prevention and Treatment of Obesity. Benefits will be provided for:

1. Well child care visit for obesity evaluation and management;

2. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);

3. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and,

4. Office visits for the treatment of childhood obesity.

5. Limitations. Benefits for the treatment of obesity are limited to Members under age nineteen (19). Benefits for preventive care and screening for obesity are available to all Members.

H. Osteoporosis Prevention and Treatment Services.

1. Definitions

Bone Mass Measurement means a radiologic or other scientifically proven technology for the purpose of identifying bone mass or detecting bone loss.

Qualified Individual, as used in this provision, means a Member:

a) Who is estrogen deficient and at clinical risk for osteoporosis;

b) With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;

c) Receiving long-term glucocorticoid (steroid) therapy;

d) With primary hyperparathyroidism; or,

e) Being monitored to assess the response to, or efficacy of, an approved osteoporosis drug therapy.

2. Covered Benefits. Benefits for Bone Mass Measurement for the prevention, diagnosis, and treatment of osteoporosis are covered when requested by a health care provider for a Qualified Individual.

1.4 Professional Nutritional Counseling and Medical Nutrition Therapy. In addition, benefits will be provided for all Medically Necessary nutritional counseling provided by a licensed dietician-nutritionist, physician, physician assistant or nurse practitioner for a Member at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition. Benefits will also be provided for all Medically Necessary medical nutrition therapy provided by a licensed dietician-nutritionist working in coordination with a primary care physician, to treat a chronic illness or condition.

1.5 Family Planning Services. Benefits will be provided for:

A. Non-Preventive Gynecological Care. Benefits are available for Medically Necessary gynecological care. Benefits for preventive gynecological care are described in Section 1.3F.

B. Nurse Midwife Services. A female Member may receive Medically Necessary obstetrical and gynecological care from a provider who is a certified nurse midwife or other health care practitioner authorized under state law to provide obstetrical and gynecological services.

A certified nurse midwife or other health care practitioner shall consult with an obstetrician/ gynecologist with whom the certified nurse midwife or other health care practitioner has a collaborative agreement, in accordance with the collaborative agreement, regarding any care rendered for the Member under this section.

C. Contraceptive Methods and Counseling. Benefits will be provided for:

1. Contraceptive patient education and counseling for all Members with reproductive capacity.

2. Benefits will be provided for all FDA approved contraceptive drugs and devices for all Members, and sterilization procedures and other contraceptive methods for female Members that must be administered to the Member in the course of a covered outpatient or inpatient treatment.

3. Coverage will be provided for the insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs that are approved by the FDA.

4. Voluntary sterilization.

See Section 11, Prescription Drugs, for coverage for self-administered FDA- approved contraceptive drugs and devices.

D. Maternity and Related Services.

1. Preventive Services.

a) Preventive outpatient obstetrical care of an uncomplicated pregnancy, including prenatal evaluation and management office visits and one post-partum office visit;

b) Prenatal laboratory tests and diagnostic services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration;

c) Preventive laboratory tests and services rendered to a newborn during a covered hospitalization for delivery, identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B," the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, including the collection of adequate samples for hereditary and metabolic newborn screening and newborn hearing screening; and

d) Breastfeeding support, supplies, and consultation.

2. Non-Preventive Services.

a) Outpatient obstetrical care and professional services for all prenatal and post-partum complications. Services include prenatal and post-partum office visits and Ancillary Services provided during those visits, such as Medically Necessary laboratory tests and diagnostic services;

b) Birthing classes, one course per pregnancy, at a CareFirst approved facility;

c) Inpatient care for delivery;

d) Coverage for care rendered at a CareFirst approved licensed birthing center;

e) Non-preventive routine professional services rendered to the newborn during a covered hospitalization for delivery. Non-routine care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as a Member in the newborn's own

right. Section 2.5 in the Evidence of Coverage describes the steps, if any, necessary to enroll a newborn Dependent Child.

f) Elective abortion.

3. Postpartum Home Visits. See Section 6.3C, Home Health Services.

E. Newborn Coverage. Coverage includes:

1. Professional services during a covered hospitalization rendered to the newborn;

2. Collection of adequate samples for hereditary and metabolic newborn screening and follow-up;

3. Newborn audiology screening prior to discharge and one confirming screening.

F. Infertility Services. Benefits for Medically Necessary, non-Experimental/Investigational artificial insemination and intrauterine insemination are covered.

1. Benefits are limited to:

a) Infertility counseling;

b) Testing;

c) Assisted reproductive technologies as described and limited below.

2. Artificial Insemination and Intrauterine Insemination.

a) Benefits are available when:

(1) The Member and the Member's Spouse have a history of the inability to conceive after one (1) year of unprotected vaginal intercourse;

(2) The Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination; and,

(3) The Member's Spouse's sperm is used.

b) Any charges associated with the collection of the Member's Spouse's sperm will not be covered unless the Spouse is also a Member.

c) Benefits are limited to six (6) attempts per live birth.

1.6 Allergy Services. Benefits are available for allergy testing and treatment, including the administration of injections and allergy serum.

1.7 Diabetes Treatment.

A. Coverage will be provided for Medically Necessary diabetes treatment and outpatient self-management training and educational services, including medical nutritional counseling at a CareFirst approved facility. Diabetic Supplies are covered under Section 11 herein. Diabetic equipment is covered under Section 10 herein.

B. The services must be Medically Necessary as determined by CareFirst for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

C. In-person, outpatient self-management training and educational services, including medical nutritional therapy, shall be provided through an in-person program provided by

an appropriately licensed, registered, or certified CareFirst-approved facility or health care provider whose scope of practice includes diabetes education or management.

1.8 Outpatient Rehabilitative Services. Benefits will be provided for Outpatient Rehabilitative Services for the treatment of individuals who have sustained an illness or injury that CareFirst determines to be subject to improvement. The goal of Outpatient Rehabilitative Services is to return the individual to his/her prior skill and functional level.

1.9 Chiropractic Services. Benefits will be provided for Medically Necessary chiropractic services when provided by a licensed chiropractor, doctor of osteopathy (D.O.) or other eligible practitioner.

1.10 Habilitative Services.

A. For Members from birth to Age 19 for treatment of Congenital or Genetic Birth Defects.

1. Benefits for Habilitative services will be provided for services including services for cleft lip and cleft palate, orthodontics, oral surgery, otologic, audiological, and speech therapy, physical therapy, and occupational therapy.

2. Benefits are not available for Habilitative services delivered through early intervention and school services.

3. Benefits are not counted toward any visit maximum for Outpatient Rehabilitation Therapy services.

B. For Members age 19 and over. Benefits are available to the same extent as benefits provided for Outpatient Rehabilitative Services.

C. Prior authorization is required.

1.11 Acupuncture Services. Benefits will be provided for Medically Necessary acupuncture services when provided by a provider licensed to perform such services.

1.12 Outpatient Therapeutic Treatment Services. Benefits are available for outpatient services rendered in a health care provider's office, in the outpatient department of a hospital, in an ambulatory surgical facility, or other facility in connection with a medical or surgical procedure covered under Section 1, Outpatient Facility, Office and Professional Services. Benefits include:

A. Hemodialysis and peritoneal dialysis;

B. Chemotherapy and radiation therapy;

C. Cardiac Rehabilitation benefits for Members who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation. Cardiac Rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Benefits include:

1. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription, and follow up examination for physician to adjust medication or change regimen; and

2. Increased outpatient rehabilitation services (physical therapy, speech therapy and occupational therapy) for Cardiac Rehabilitation of 90 visits per therapy per Benefit Period.

3. Services must be provided at a place of service equipped and approved to provide Cardiac Rehabilitation.

D. Pulmonary rehabilitation benefits for Members who have been diagnosed with significant

pulmonary disease.

1. Limited to one (1) program per lifetime.

2. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation services;

E. Infusion, including home infusion therapy, and transfusion services;

F. Electroshock therapy; and,

G. Radioisotope treatment.

1.13 Blood and Blood Products. Benefits are available for cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums, including: autologous services; whole blood; red blood cells; platelets; plasma; immunoglobulin; and albumin.

1.14 Controlled Clinical Trials.

A. Benefits will be provided to a Member in a Controlled Clinical Trial will be provided if the Member's participation in the Controlled Clinical Trial is the result of:

1. Treatment provided for a life-threatening condition; or,

2. Prevention, early detection, and treatment studies on cancer.

B. Coverage will be provided only if:

1. 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,

2. 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;

3. 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;

4. There is no clearly superior, non-Investigational treatment alternative; and,

5. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Investigational alternative.

6. Prior authorization has been obtained from CareFirst.

C. 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.

1.15 Dental Services. Pediatric dental benefits for Members up to age 19 are described in Section 2. Benefits will be provided to all Members for the following:

A. Accidental Injury.

1. Covered Benefits. Dental benefits 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 six (6) months of the injury or, if due to the nature of the injury, treatment could not begin within six (6) months of the injury, treatment began within six (6)

months of the earliest date that it would be medically appropriate to begin such treatment.

As used in this provision, accidental injury means an injury to Sound Natural Teeth as a result of an external force or trauma resulting in damage to a tooth or teeth, surrounding bone and/or jaw.

2. Conditions and Limitations. Benefits are limited to Medically Necessary dental services such as restoration of the tooth or teeth or 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. Except as listed here, or in Section 1.17 describing benefits for the treatment of cleft lip or cleft palate or both, or Section 2, Pediatric Dental Services, dental care is excluded from coverage. Benefits for oral surgery are described below.

B. 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:

1. If the Member is:

   a) Seven (7) years of age or younger, or developmentally disabled;

   b) 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,

   c) An individual for whom a superior result can be expected from dental care provided under general anesthesia.

2. Or, if the Member is:

   a) Seventeen (17) years of age or younger;

   b) An extremely uncooperative, fearful, or uncommunicative individual;

   c) An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and,

   d) An individual for who lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

3. Or, if the Member has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.

4. Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:

   a) A fully accredited specialist in pediatric dentistry;

   b) A fully accredited specialist in oral and maxillofacial surgery; and,

   c) A dentist who has been granted hospital privileges.

5. This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.

6. This provision does not provide benefits for the dental care for which the general anesthesia is provided.

7. Prior authorization for the anesthesia services was obtained from CareFirst.

1.16 Oral Surgery.

A. Benefits for oral surgery include:

1. Medically Necessary procedures, as determined by CareFirst, to attain functional capacity, correct a congenital anomaly (excluding odontogenic congenital anomalies or anomalies limited to the teeth), reduce a dislocation, repair a fracture, excise tumors, non-odontogenic cysts or exostoses, or drain abscesses involving cellulitis and are performed on the lips, tongue, roof, and floor of the mouth, sinuses, salivary glands or ducts, and jaws.

2. Medically Necessary procedures, as determined by CareFirst, needed as a result of an accidental injury, when the Member requests oral surgical services or dental services for Sound Natural Teeth and supporting structures or the need for oral surgical services or dental services for Sound Natural Teeth and supporting structures is identified in the patient's medical records within sixty (60) days of the accident. Benefits for such oral surgical services shall be provided up to three (3) years from the date of injury.

B. Medically Necessary surgical treatment, as determined by CareFirst, for Temporomandibular Joint Syndrome (TMJ). Except as provided in Section 2, Pediatric Dental Services, all other treatments or procedures for the treatment of TMJ are excluded.

C. All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.

1.17 Treatment for Cleft Lip or Cleft Palate or Both. Benefits will be provided for inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological, and speech/language treatment for cleft lip or cleft palate or both.

1.18 Outpatient Surgical Procedures.

A. Benefits are available for surgical procedures performed by health care providers on an outpatient basis.

B. Benefits are available for services in a hospital outpatient department or in an ambulatory surgical facility, in connection with a covered surgical procedure, including:

1. Use of operating room and recovery room.

2. Use of special procedure rooms.

3. Diagnostic procedures, laboratory tests and radiology services.

4. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

5. Medical and surgical supplies.

6. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administration of infusions is covered.

1.19 Anesthesia Services for Medical or Surgical Procedures. Benefits are available for the administration of general anesthesia in connection with a covered medical or surgical procedure. To be eligible for separate coverage, a health care provider other than the operating surgeon or

assistant at surgery must administer the anesthesia. For example, a local anesthetic used while performing a medical or surgical procedure is not generally viewed as a separately covered charge.

1.20 Reconstructive Surgery.
Benefits for reconstructive surgery 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.

1.21 Reconstructive Breast Surgery. Benefits will be provided for reconstructive breast surgery resulting from a Mastectomy.

A. Reconstructive breast surgery means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery includes:

1. Augmentation mammoplasty;

2. Reduction mammoplasty; and

3. Mastopexy.

B. Benefits are provided for all stages of reconstructive breast surgery performed on the non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery on the diseased breast is performed.

C. Benefits are provided regardless of whether the Mastectomy was performed while the Member was covered under this Evidence of Coverage.

D. Coverage will be provided for treatment of physical complications at all stages of Mastectomy, including lymphedemas, in a manner determined in consultation with the Member and the Member's attending physician.

1.22 Morbid Obesity. Benefits are provided for Medically Necessary surgical services for the treatment of Morbid Obesity, as determined by CareFirst. The procedures must be recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity and consistent with guidelines approved by the National Institutes of Health. Benefits are subject to the same terms and conditions as other Medically Necessary surgical procedures.

Surgical treatment of Morbid Obesity shall occur at a facility that is designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence and is designated by CareFirst.

1.23 Wellness Benefits. Benefits will be provided for:

A. A health risk assessment that is completed by each Member on a voluntary basis; and,

B. Written feedback to the individual who completes the health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.

SECTION 2
PEDIATRIC DENTAL SERVICES

2.1 Covered Services. Pediatric dental benefits will be provided through the Dental Plan for Members up to the end of the Calendar Year in which the Member turns age 19 in accordance with the Maryland Children's Health Insurance Plan dental benefits, which includes benefits for periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry and as specified in the Schedule of Benefits.

2.2 Class I - Preventive and Diagnostic Services.

A. Services limited to twice per Benefit Period.

1. Oral examination including oral health risk assessment.

2. Routine cleaning of teeth (dental prophylaxis).

3. Topical application of fluoride.

4. Bitewing x-ray (not taken on the same date as those in 2.2C below)

5. Intraoral occlusal x-ray.

6. Pulp vitality tests; additional tests may be allowed for accidental injury and trauma, or other emergency.

B. Topical fluoride varnish (D1206) limited to eight (8) per twelve (12) months per Member ages zero to two(2) and four (4) per twelve (12) months per Member ages three (3) and above until the end of the Calendar Year in which the Member turns age nineteen (19).

C. Services limited to one per 36 months:

1. Intraoral complete series x-ray (full mouth x-ray including bitewings) **OR** one panoramic x-ray and one additional set of bitewing x-rays.

2. One cephalometric x-ray.

D. Services limited to once per tooth per 60 months: sealants on permanent molars.

E. Services limited to once per quadrant per 24 months: space maintainers when Medically Necessary due to the premature loss of a posterior primary tooth.

F. Services as required.

1. Palliative Treatments once per date of service.

2. Emergency Oral Exam once per date of service.

3. Periapical and occlusal x-rays limited to the site of injury or infection.

4. Professional consultation rendered by a Dentist, limited to one consultation per condition per Dentist other than the treating Dentist.

5. Temporomandibular joint (TMJ) arthograms, including injection, and other TMJ films, by report.

2.3 Class II - Basic Services.

A. Direct placement fillings limited to:

1. Silver amalgam, resin-based composite, compomer, glass-ionomer or equivalent material accepted by the American Dental Association and/or the United States Food and Drug Administration.

2. One filling per 12 months, per tooth, per surface.

3. Direct pulp caps and indirect pulp caps.

B. Non-surgical periodontic services limited to:

1. Periodontal scaling and root planing limited to once per 24 months per quadrant.

2. Provision splinting, intracoronal and extracoronal.

3. Full mouth debridement to enable comprehensive periodontal procedure limited to one per 24 months.

4. Periodontal maintenance procedures limited to two per 12 months.

C. Simple extractions performed without general anesthesia limited to once per tooth per lifetime.

2.4 Class III - Major Services - Surgical.

A. Surgical periodontic services.

1. Gingivectomy or gingivoplasty limited to one treatment per 24 months per Member per quadrant or per tooth, and limited to two quadrants per 12 months.

2. Osseous surgery (including flap entry and closure) limited to one treatment per 24 months per Member per quadrant.

3. Limited or complete occlusal adjustments in connection with periodontal treatment when services are received on a different date than restorative services.

4. Mucogingival surgery limited to grafts and plastic procedures; one treatment per site.

B. Endodontics

1. Apicoectomy, limited to one per Member, per tooth, per lifetime.

2. Pulpotomy for deciduous teeth limited to once per tooth per lifetime per Member.

3. Root canal for permanent teeth limited to once per tooth per lifetime per Member.

4. Root canal retreatment performed on permanent teeth limited to once per tooth per lifetime per Member.

5. Root resection.

6. Pulpal therapy limited to once per tooth per lifetime per Member.

7. Endodontic therapy limited to once per tooth per lifetime per Member.

C. Oral surgical services as required.

1. Simple and surgical extractions, including impactions, limited to once per tooth per lifetime per Member.

2. Oral surgery, including treatment for cysts, tumors and abscesses.

3. Biopsies of oral tissue if a biopsy report is submitted.

4. Hemi-section: one per Member, per tooth, per lifetime

5. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

6. Vestibuloplasty.

7. Services limited to once per lifetime per tooth:

a) Coronectomy.

b) Tooth transplantation.

c) Surgical repositioning of teeth.

d) Alveoloplasty.

e) Frenulectomy.

f) Excision of pericoronal gingiva.

D. In addition to the benefits stated in Section 1.15B, general anesthesia, intravenous (IV) sedation/analgesia, inhalation of nitrous oxide/anxiolysis, analgesia, and non-intravenous conscious sedation when Medically Necessary.

2.5 Class IV - Major Services - Restorative.

A. Crowns.

1. Metal and/or porcelain/ceramic crowns and crown build-ups limited to one per 60 months per tooth.

2. Metal and/or porcelain/ceramic inlays and onlays limited to one per 60 months per tooth.

3. Stainless steel crowns.

4. Recementation of crowns and/or inlays limited to once in any twelve (12) month period.

B. Dentures

1. Partial removable dentures, upper or lower, limited to one per 60 months.

2. Complete removable dentures, upper or lower, limited to one per 60 months.

3. Pre-operative radiographs required.

4. Pre-treatment estimate, as described in Section 14.3F, Estimate of Eligible Benefits, is recommended.

5. Tissue conditioning prior to denture impression only.

6. Repairs to denture as required including: repair resin denture base, repair cast

framework, addition of tooth or clasp to existing partial denture, replacement of broken tooth, repairs or replacement of clasp, recement fixed partial denture.

7. Adjustment to maxillofacial prosthetic appliance, by report, limited to one per 6 months, per Member.

8. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, limited to one per 6 months, per Member, per arch.

C. Denture adjustments and relining limited to: Full or partial removable (upper or lower) dentures: once per 24 months, but not within six months of initial placement

D. Repair of prosthetic appliances, including removable dentures, full and/or partial.

E. Occlusal guard, by report, limited to one per 24 months, per Member

F. Fabrication of athletic mouthguard limited to one per 12 months.

G. Occlusal adjustment, limited, if provided when no other restorative procedure is provided on the same date of service, limited to two per 12 months.

H. Occlusal adjustment, complete, if provided when no other restorative procedure is provided on the same date of service, limited to one per 12 months.

2.6 Class V - Orthodontic Services.

A. Benefits for orthodontic services will only be available if the Member:

1. Has fully erupted permanent teeth with at least 1/2 to 3/4 of the clinical crown being exposed (unless the tooth is impacted or congenitally missing); and

2. Has a severe, dysfunctional, handicapping malocclusion that meets a minimum score of 15 on the Handicapping Labio-Lingual Deviations Index (HLD) approved for use by the State of Maryland. Points are not awarded for aesthetics, therefore additional points for handicapping aesthetics will not be considered as part of the determination.

B. All orthodontic services require a pre-treatment estimate (PTE) by CareFirst, as described in Section 14.3F, Estimate of Eligible Benefits. The following documentation must be submitted with the request for PTE:

1. ADA 2006 or newer claim form with service code requested;

2. Diagnostic study models (trimmed) with waxbites or OrthoCAD™ electronic equivalent,

3. Cephalometric head film with measurements and analysis;

4. Panoramic or full series periapical radiographs;

5. Clinical summary with diagnosis;

6. HLD score sheet completed and signed by the orthodontist; and

7. Treatment plan including anticipated duration of active treatment.

C. Covered benefits if PTE is obtained:

1. Retainers:

a) One set (included in comprehensive orthodontics);

b) Replacement allowed one per arch per lifetime within 24 months of date of debanding, if necessary; and,

c) Rebonding or recementing fixed retainer.

2. Pre-orthodontic treatment visit.

3. Braces limited to once per lifetime

4. Periodic treatment visits; not to exceed 24 months. The Member must be eligible for Covered Dental Services on each date of service, except as specifically stated in the Extension of Benefits section of the Evidence of Coverage.

D. Payment policy: one initial payment for comprehensive orthodontic treatment, a pre-orthodontic treatment visit and periodic orthodontic treatment visits (not to exceed 24 periodic orthodontic treatment visits).

1. When a Preferred Dentist or Participating Dentist provides the comprehensive orthodontic treatment, additional periodic orthodontic treatment visits beyond 24 will be the orthodontist's financial responsibility and not the Subscriber's. Subscribers may not be billed for broken, repaired, or replacement of brackets or wires. Visits to repair or replace brackets or wires are not separately reimbursable from periodic visits.

2. When a Non-Participating Dentist provides the comprehensive orthodontic treatment, additional periodic orthodontic treatment visits beyond 24 will not be Covered Dental Services. The Member is responsible for the difference between the CareFirst payment for Covered Dental Services and the Non-Participating Dentist's charge.

SECTION 3
PEDIATRIC VISION SERVICES

3.1 Covered Services. Coverage will be provided for pediatric vision benefits for children up to age 19 in accordance with the Federal Employee Program Blue Vision high plan. Benefits include:

A. One routine eye examination, including dilation, if professionally indicated, each Benefit Period. A vision examination may include, but is not limited to:

1. Case history;

2. External examination of the eye and adnexa;

3. Ophthalmoscopic examination;

4. Determination of refractive status;

5. Binocular balance testing;

6. Tonometry test for glaucoma;

7. Gross visual field testing;

8. Color vision testing;

9. Summary finding; and

10. Recommendation, including prescription of corrective lenses.

B. Frames and Spectacle Lenses or Contact Lenses

1. Prescribed frames and spectacle lenses or contact lenses, including directly related provider services such as:

a) Measurement of face and interpupillary distance;

b) Quality assurance; and

c) Reasonable aftercare to fit, adjust and maintain comfort and effectiveness.

2. One pair of frames per Benefit Period; and

3. One pair of prescription spectacle lenses per Benefit Period

a) Spectacle lenses include choice of glass or plastic lenses and all lens powers (single vision, bifocal, trifocal, lenticular). Fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, ultraviolet protective coating, standard progressives, and plastic photosensitive lenses (Transitions®) are non-Covered Vision Services.

b) Scratch resistant coating.

4. Contact Lenses

a) Contact lens evaluation, fitting, and follow-up care.

b) Elective contact lenses (in place of frames and spectacle lenses):

(1) One pair of elective prescription contact lenses per Benefit Period; or,

(2) Multiple pairs of disposable prescription contact lenses per Benefit Period.

c) One pair of Medically Necessary prescription contact lenses per Benefit Period in lieu of other eyewear.

(1) Prior authorization must be obtained from the Vision Care Designee by calling the Vision Care Designee at the telephone number on the Member's identification card.

(2) Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. Contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and/or irregular astigmatism.

C. Low vision services, including one comprehensive Low Vision evaluation every 5 years, 4 follow-up visits in any 5-year period and prescribed optical devices, such as high-powered spectacles, magnifiers and telescopes.

1. Ophthalmologists and optometrists specializing in low vision care will evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with low vision.

2. Prior authorization is required for low vision services. Contracting Vision Providers will obtain the necessary prior authorization for these services. For Covered Vision Services rendered by Non-Contracting Vision Providers, the Member is required to obtain prior authorization from the Vision Care Designee by calling the telephone number listed on the Member's identification card.

D. Covered Vision Services are limited as stated in the Schedule of Benefits.

3.2 Warranty. The Vision Care Designee's collection frames and all eyeglass lenses manufactured in the Vision Care Designee laboratories are guaranteed for one year from the original date of dispensing. Warranty limitations may apply to provider-supplied or retailer- supplied frames and/or eyeglass lenses. The Contracting Vision Provider can provide the details of the warranty that is available to the Member.

3.3 Limitations. Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year. Benefits for treatment of medical conditions of the eye are covered under Section 1. Benefits will not be provided for add-ons to basic spectacle lenses. Non-collection frames and non-collection contact lenses are not covered under this Evidence of Coverage when obtained from a Contracting Provider.

SECTION 4
INPATIENT HOSPITAL SERVICES

4.1 Covered Inpatient Hospital Services. A Member will receive benefits for Covered Services listed below when admitted to a hospital. Coverage of inpatient hospital services is subject to certification by Utilization Management for Medical Necessity. Except for maternity and Emergency admissions, prior authorization is required. Benefits are provided for:

A. Room and Board. Room and board in a semiprivate room (or in a private room when Medically Necessary as determined by CareFirst).

B. Physician and Medical Services. Medically Necessary inpatient physician and medical services provided by or under the direction of the attending health care provider and ordinarily furnished to a patient while hospitalized.

Payment for Ancillary Services may not be denied solely based on the fact that the denial of the hospitalization day was appropriate. Instead a denial of inpatient Ancillary Services must be based on the Medical Necessity of the specific Ancillary Service. In determining the Medical Necessity of an Ancillary Service performed on a denied hospitalization day, consideration must be given to the necessity of providing the Ancillary Service in the acute setting for each day in question.

C. Services and Supplies. Related inpatient services and supplies that are not Experimental/ Investigational, as determined by CareFirst, and ordinarily furnished by the hospital to its patients, including:

1. The use of:

a) Operating rooms;

b) Treatment rooms; and

c) Special equipment in the hospital.

2. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

3. Medical and surgical supplies.

4. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administrations of infusions and transfusions are covered.

5. Surgically implanted Prosthetic devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants and pacemakers. Available benefits under this provision do not include items such as artificial limbs or eyes, hearing aids, or other external prosthetics, which may be provided under other provisions of the Description of Covered Services.

6. Medical social services.

4.2 Number of Hospital Days Covered.
Provided the conditions, including the requirements below, are met and continue to be met, as determined by CareFirst, hospital benefits for Inpatient Hospital Services will be provided as follows:

A. Inpatient Coverage Following a Mastectomy. Coverage will be provided for a minimum hospital stay of not less than:

1. Forty-eight (48) hours following a radical or modified radical Mastectomy; and

2. Twenty-four (24) hours following a partial Mastectomy with lymph node dissection.

In consultation with the Member's attending physician, the Member may elect to stay less than the minimum prescribed above when appropriate.

B. Hysterectomies. Coverage will be provided for vaginal hysterectomies and abdominal hysterectomies. Coverage includes a minimum stay in the hospital of:

1. Not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy; and

2. Not less than forty-eight (48) hours for a vaginal hysterectomy.

In consultation with the health care provider, the Member may elect to stay less than the minimum prescribed above when appropriate.

C. Childbirth. Coverage will be provided for a minimum hospital stay of not less than:

1. Forty-eight (48) hours for both the mother and newborn following a routine vaginal delivery;

2. Ninety-six (96) hours for both the mother and newborn following a routine cesarean section.

Prior authorization is not required for maternity admissions.

Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, coverage includes additional hospitalization for the newborn for up to four (4) days.

If the delivery occurs in the hospital, the length of stay begins at the time of the delivery. If the delivery occurs outside of the hospital the length of stay begins upon admission to the hospital. The Member and provider may agree to an early discharge.

Non-routine care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as a Member in the newborn's own right. Section 2.5 in the Evidence of Coverage describes the steps, if any, necessary to enroll a newborn Dependent Child.

4.3 Organ and Tissue Transplants.

A. Coverage is provided for all Medically Necessary, non-Experimental/Investigational bone marrow, solid organ transplant, and other non-solid organ transplant procedures. Medical Necessity is determined by CareFirst. Except for cornea transplants and kidney transplants, prior authorization must be obtained from CareFirst.

B. Covered services include the following:

1. The expenses related to registration at transplant facilities. The place of registry is subject to review and determination by CareFirst.

2. Organ procurement charges including harvesting, recovery, preservation, and transportation of the donated organ.

3. Cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of eighteen (18) years) to and from the site of the transplant.

4. There is no limit on the number of re-transplants that are covered.

5. If the Member is the recipient of a covered organ/tissue transplant, CareFirst will cover the Donor Services (as defined below) to the extent that the services are not covered under any other health insurance plan or contract.

Donor Services means Covered Services 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 is directly related to donating the organ or tissue.

6. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant.

4.4 Other Inpatient Services. Benefits are available for all other care in the nature of usual hospital services that are Medically Necessary for the care and treatment of the patient, provided that those services cannot be rendered in an outpatient setting and are not otherwise specifically excluded.

SECTION 5
SKILLED NURSING FACILITY SERVICES

5.1 Covered Skilled Nursing Facility Services. When the Member meets the conditions for coverage listed in Section 5.2, the services listed below are available to Members in a Skilled Nursing Facility:

A. Room and board in a semiprivate room;

B. Inpatient physician and medical services;

C. Services and supplies that are not Experimental/Investigational as determined by CareFirst and ordinarily furnished by the facility to inpatients for diagnosis or treatment.

5.2 Conditions for Coverage. Skilled Nursing Facility care must be authorized or approved by CareFirst as meeting the following conditions for coverage:

A. The admission to the Skilled Nursing Facility must be a substitute for hospital care (i.e., if the Member were not admitted to a Skilled Nursing Facility, he or she would have to be admitted to a hospital).

B. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.

C. The Member must require Skilled Nursing Care or skilled rehabilitation services which are:

1. Required on a daily basis;

2. Not Custodial; and,

3. Only provided on an inpatient basis.

D. Prior authorization has been obtained from CareFirst.

5.3 Custodial Care is Not Provided. Benefits will not be provided for any day in a Skilled Nursing Facility that CareFirst determines is primarily for Custodial Care. Services may be deemed Custodial Care even if:

A. A Member cannot self-administer the care;

B. No one in the Member's household can perform the services;

C. Ordered by a physician;

D. Necessary to maintain the Member's present condition; or

E. Covered by Medicare.

SECTION 6
HOME HEALTH CARE SERVICES

6.1 Covered Home Health Services. Benefits are provided for:

A. Continued care and treatment provided by or under the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Services of a home health aide, medical social worker or registered dietician may be provided, but must be performed under the supervision of a licensed professional (RN or LPN) nurse.

B. Drugs and medications:

1. Directly administered to the patient during a covered home health visit and incidental Medical Supplies directly expended in the course of a covered home health visit; and,

2. Drugs, medications and Medical Supplies for home use. Purchase or rental of Durable Medical Equipment is not covered under this provision. See Section 10.1A, Durable Medical Equipment, for benefit information.

C. Home Health Services authorized or approved by CareFirst as Medically Necessary.

D. Prior authorization is required..

6.2 Conditions for Coverage. Benefits are provided when:

A. The Member must be confined to home due to a medical, non-psychiatric condition. "Home" cannot be an institution, convalescent home, or any facility which is primarily engaged in rendering medical or rehabilitative services to sick, disabled, or injured persons.

B. The Home Health Care Visits are 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).

C. The Member requires and continues to require Skilled Nursing Care or rehabilitation services in order to qualify for home health aide services or other types of Home Health Care Services.

D. The need for Home Health Care Services is not Custodial in nature.

E. Services of a home health aide, medical social worker, or registered dietician must be performed under the supervision of a licensed professional nurse (R.N. or L.P.N.).

F. All services must be arranged and billed by the Qualified Home Health Agency. Providers may not be retained directly by the Member.

G. Prior authorization has been obtained from CareFirst.

6.3 Additional Home Health Care Benefits.

A. Home Visits Following 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, benefits will be provided for:

1. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and

2. An additional home visit if prescribed by the Member's attending physician.

3. Prior authorization is not required..

B. Home Visits Following Mastectomy. For a Member who receives less than 48 hours of inpatient hospitalization following the Mastectomy, or who undergoes the Mastectomy on an outpatient basis, benefits will be provided for:

1. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and

2. An additional home visit if prescribed by the Member's attending physician.

3. Prior authorization is not required.

C. Postpartum Home Visits. Home visits following delivery are covered in accordance with the most current standards published by the American College of Obstetricians and Gynecologists.

1. For a mother and newborn child who have a shorter hospital stay than that provided under Section 4.2C, Childbirth, benefits will be provided for:

   a) One home visit scheduled to occur within 24 hours after hospital discharge; and

   b) An additional home visit if prescribed by the attending provider.

2. For a mother and newborn child who remain in the hospital for at least the length of time provided under Section 4.2C, Childbirth, benefits will be provided for a home visit if prescribed by the attending provider.

3. Prior authorization is not required.

SECTION 7
HOSPICE CARE SERVICES

7.1 Covered Hospice Care Services. Benefits will be provided for terminally ill Members for the services listed below when provided by a Qualified Hospice Care Program. Coverage for hospice care services is subject to certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements. Prior authorization is required.

A. Inpatient and outpatient care.

B. Intermittent nursing care by or under the direction of a registered nurse;

C. Medical social services for the terminally ill patient and his or her Immediate Family;

D. Counseling, including dietary counseling, for the terminally ill Member;

E. Non-Custodial home health visits.

F. Services, visits, medical/surgical equipment, or supplies, including equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member;

G. Laboratory test and x-ray services;

H. Medically Necessary ground ambulance, as determined by CareFirst;

I. Respite Care.

J. Family Counseling will be provided to the Immediate Family and the Family Caregiver before the death of the terminally ill Member, when authorized or approved by CareFirst;

K. Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Member for the six (6) month period following the Member's death or fifteen (15) visits, whichever occurs first.

7.2 Conditions for Coverage. Hospice care services must be certified by CareFirst, provided by a Qualified Hospice Care Program, and meet the following conditions for coverage:

A. The Member must have a life expectancy of six (6) months or less;

B. The Member's attending physician must submit a written hospice care services Plan of Treatment to CareFirst;

C. The Member must meet the criteria of the Qualified Hospice Care Program;

D. Prior authorization has been obtained from CareFirst.

E. The need and continued appropriateness of hospice care services must be certified by CareFirst as meeting the criteria for coverage in accordance with CareFirst utilization management requirements.

7.3 Hospice Eligibility Period. The hospice eligibility period begins on the first date hospice care services are rendered and terminates one hundred eighty (180) days later or upon the death of the terminally ill Member, if sooner. If the Member requires an extension of the eligibility period, the Member or the Member's representative must notify CareFirst in advance to request an extension of benefits. CareFirst reserves the right to extend the eligibility period on an individual case basis if CareFirst determines that the Member's prognosis and continued need for services are consistent with a program of hospice care services.

SECTION 8
INPATIENT AND OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

8.1 Professional Services. Professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of his/her license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists

A. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:

1. Diagnostic evaluation;

2. Crisis intervention and stabilization for acute episodes;

3. Medication evaluation and management (pharmacotherapy);

4. Treatment and counseling (including individual and group therapy visits);

5. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;

6. Professional charges for intensive outpatient treatment in a provider's office or other professional setting.

B. Electroconvulsive therapy;

C. Inpatient professional fees;

D. Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner;

E. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility;

F. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.

8.2 Inpatient Hospital and Inpatient Residential Treatment Centers Services. Coverage will be provided for:

A. Room and board such as:

1. Ward, semiprivate or intensive care accommodations. Private room is covered only if Medically Necessary. If a private room is not Medically Necessary, CareFirst will only cover the hospital's average charge for semiprivate accommodations.

2. General nursing care;

3. Meals and special diets.

B. Other facility services and supplies. Services provided by a hospital or residential treatment center (RTC).

C. Prior authorization must be obtained from CareFirst.

8.3. Outpatient Hospital. Services such as partial hospitalization or intensive day treatment programs.

8.4. Emergency Room Services. Outpatient services and supplies billed by a hospital for emergency room treatment.

SECTION 9
EMERGENCY SERVICES AND URGENT CARE

9.1 Emergency Services and Urgent Care.

A. Benefits are available to a Member for Emergency Services and Urgent Care twenty-four (24) hours per day.

B. In the case of a hospital that has an emergency department, benefits include:

1. Appropriate medical screening;

2. Assessment and stabilization services;

3. Ancillary services routinely available to the emergency department to determine whether or not an Emergency Medical Condition exists; and

4. Medically Necessary observation to determine whether the Member's condition requires inpatient hospitalization.

C. A provider is not required to obtain prior authorization or approval from CareFirst in order to obtain reimbursement for Emergency Services or Urgent Care.

9.2 Notice to CareFirst in the Event of an Emergency.

A. If the Member is admitted to a hospital as a result of an Emergency Medical Condition, CareFirst must be notified the earlier of:

1. The end of the first business day after first receiving the care; or

2. Within 48 hours after first receiving the care.

B. If it was not reasonably possible to give notice, this requirement will be met if notice was given as soon as reasonably possible. The Member must provide information about the Emergency Medical Condition and the care received.

9.3 Ambulance Services.

A. Benefits are available for Medically Necessary air transportation and ground ambulance services.

B. If a Member is outside of the United States and requires treatment for Emergency Services, benefits are provided for Medically Necessary air and ground transportation to the nearest facility where appropriate medical care is available.

9.4 Filing a Claim for a Non-Preferred Provider. When a Member receives Emergency Services or Urgent Care from a Non-Preferred Provider, the Member must follow the proof of loss requirements of Section 6.2B of the Evidence of Coverage.

SECTION 10
MEDICAL DEVICES AND SUPPLIES

10.1 Covered Services. Benefits will be provided for:

A. Durable Medical Equipment including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses.

B. Breast Prostheses. Coverage will be provided for prostheses for a Member who has undergone a Mastectomy and has not had breast reconstruction.

C. Medical food for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders.

D. Hearing aid for Members from birth to age 18. Coverage will be provided for one hearing aid for each hearing-impaired ear every 36 months.

E Diabetes Equipment and Supplies.

1. Diabetes equipment includes glucose monitoring equipment under the durable medical equipment coverage for insulin-using beneficiaries. Coverage will be provided for insulin pumps.

2. Diabetes supplies include coverage for insulin syringes and needles and testing strips for glucose monitoring equipment under the prescription drug coverage for insulin-using beneficiaries.

3. Insulin using beneficiary means a Member who uses insulin as part of a treatment plan prescribed by his/her medical care provider.

10.2 Repairs. Benefits for the repair, maintenance, or replacement of covered Durable Medical Equipment are limited as follows:

A. Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating, and checking of equipment.

B. Coverage of repairs 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 appliance, prosthetic, or equipment.

C. Replacement coverage is limited to once every two (2) 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.

10.3 Benefit Limits. Benefits for a Medical Device will be limited to the lesser of purchase price of the item or the Allowed Benefit for least expensive of its type adequate to meet the medical needs of the Member. If the Member selects a deluxe version of the appliance, device, or equipment, CareFirst will pay an amount that does not exceed CareFirst's payment for the basic device (minus any Member Deductible, Copayment or Coinsurance) and the Member will be fully responsible for paying the remaining balance.

10.4 Responsibility of CareFirst. CareFirst will not be liable for any claim, injury, demand, or judgment based on tort or other grounds (including warranty of equipment), arising out of or in connection with the rental, sale, use, maintenance, or repair of prosthetic devices, corrective appliances or durable medical equipment, whether or not a Covered Service.

SECTION 11
PRESCRIPTION DRUGS

11.1 Covered Services. Benefits will be provided for Prescription Drugs, including but not limited to:

A. Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preferred Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. See Section 1.5C, Contraceptive Methods and Counseling, for additional coverage of contraceptive drugs and devices.

B. Human growth hormones. Prior authorization is required.

C. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preferred Preventive Drug List.

Nicotine Replacement Therapy. Nicotine Replacement Therapy means a product, including a product on the Preferred Preventive Drug List that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.

D. Injectable medications that are self-administered and the prescribed syringes.

E. Standard covered items such as insulin, glucagon and anaphylaxis kits.

F. Fluoride products.

G. Diabetic Supplies.

H. Infertility drugs or agents, prescribed in connection with, and subject to the limitations of, covered infertility services.

11.2 Mail Order Program. All Members have the option of ordering Prescription Drugs via mail order. Members ordering Prescription Drugs through the mail order program will be entitled to a thirty-four (34) day supply for non-Maintenance Drugs and a ninety (90) day supply for Maintenance Drugs.

SECTION 12
PATIENT-CENTERED MEDICAL HOME

12.1 Definitions.

Care Coordination Team means the health care providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan, as used in this provision, means the plan directed by a health care provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

Patient-Centered Medical Home Program ("PCMH") means medical and associated services directed by the PCMH team of medical professionals to:

A. Foster the health care provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;

B. Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and,

C. Exchange medical information with CareFirst, other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.

Qualifying Individual, as used in this provision, means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the PCMH.

12.2 Covered Benefits. Benefits will be provided for the costs associated with the coordination of care for the Qualifying Individual's medical conditions, including:

A. Assess the Qualifying Individual's medical needs;

B. Provide liaison services between the Qualifying Individual and the health care provider(s) and the Care Coordination Team;

C. Create and supervise the Care Plan;

D. Educate the Qualifying Individual and family regarding the Qualifying Individual's disease and self-care techniques;

E. Arrange for consultations with Specialists and other Medically Necessary supplies and services, including community resources, for the Member; and,

F. Assess treatment compliance.

12.3 Limitations. Benefits provided through the Patient-Centered Medical Home Program are available only when provided by a CareFirst-approved health care provider who has elected to participate in the PCMH.

SECTION 13
COMPLEX CHRONIC OR HIGH RISK ACUTE DISEASE MANAGEMENT

13.1 Definitions.

Care Plan means the plan of treatment created for a Qualified Individual under the Patient-Centered Medical Home Program (PCMH), through CareFirst Complex Case Management working in conjunction with the Qualified Individual's treating physician or nurse practitioner, or through a Chronic Care Coordination Program developed or implemented by a Chronic Care Coordinator.

Chronic Care Coordinator (CCC) means a registered nurse who develops and implements treatment plans for Qualified Individuals with chronic medical conditions in coordination with those treating physicians or nurse practitioners who do not participate in the CareFirst PCMH.

Complex Case Management (CCM) means the coordination of specialty services provided to a Qualified Individual with advanced or critical illnesses by Specialty Case Managers (SCM).

Designated Provider means a provider of a Chronic Care Coordination Program (CCP), Comprehensive Medication Review (CMR), Enhanced Monitoring Program (EMP), Expert Consultation Program (ECP), or Home Based Services Program (HBS), outlined in this provision, who has been contracted by CareFirst to provide these services and who has agreed to participate in care coordination activities in cooperation with CareFirst for Qualified Individuals with complex chronic disease or high risk acute conditions.

Home-Based Care Management Plan means the designated medical and associated services prescribed for a Qualified Individual with a high risk of admission or readmission to a hospital.

Home Care Coordinator (HCC) means a registered nurse or other provider licensed or otherwise authorized by law to provide home care working in conjunction with the Qualified Individual's treating physician, nurse practitioner, SCM or LCC.

Local Care Coordinator (LCC) means a registered nurse who develops and implements Care Plans for Qualified Individuals with chronic medical conditions in coordination with those treating physicians or nurse practitioners who participate in the CareFirst PCMH program.

Qualified Individual, as used in this provision, means a Member who:

A. Is accepted by CareFirst into one or more of the programs described in this provision. CareFirst will consult with the treating physician or nurse practitioner in order to determine whether the Member has a medical condition which meets the parameters for participation in one or more of the programs. CareFirst retains final authority to determine whether someone who meets the parameters for participation in a program will be accepted as a Qualified Individual.

B. Consents to participate and complies with all elements of the program(s) in which he/she qualifies.

C. Continues to meet the program criteria for participation and participates fully with any applicable plan of treatment. CareFirst and the Qualified Individual's treating physician or nurse practitioner will determine whether the Member is cooperating with the Home-Based Care Management Plan, Care Plan and/or plan of treatment.

Specialty Case Manager (SCM) means a registered nurse who works with a treating physician or nurse practitioner in order to coordinate the care needs of Qualified Individuals with complex medical conditions in accordance with the guiding principles of case management for complex specialty care including, but not limited to, oncology, hospice, rehabilitation, trauma, and high risk pregnancy.

13.2 The following benefits are available to Qualified Individuals to manage the care of complex chronic or high-risk acute diseases when provided by Designated Providers or through CareFirst:

A. Chronic Care Coordination Program (CCP). Benefits will be provided for a Designated Provider to work telephonically or otherwise with a chronically ill Qualified Individual and his/her treating physician or nurse practitioner to develop and implement a treatment plan.

B. Complex Case Management (CCM). Specialty Case Managers will initiate and perform CCM services, as deemed Medically Necessary by the Member's treating physician or nurse practitioner and CareFirst. Benefits include:

1. Assessment of Qualified Individual/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;

2. Education of Qualified Individual/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;

3. Assistance in navigating and coordinating health care services and understanding benefits;

4. Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Individual's care with Specialty Case Managers;

5. Assistance in arranging consultation(s) with physician Specialists;

6. Locating community resources, and other organizations/support services to supplement the Care Plan;

7. Implementation of a Care Plan in consultation with the Qualified Individual's treating physician or nurse practitioner.

C. Comprehensive Medication Review (CMR). Benefits will be provided for a pharmacist's review of medications and consultation with the Qualified Individual to improve the effectiveness of pharmaceutical therapy.

D. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Individual with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Individual's chronic condition or disease.

E. Expert Consultation Program (ECP). Benefits will be provided for a review by a Specialist of a Qualified Individual's medical records where the Qualified Individual has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

F. Home Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in the Home-Based Care Management Plan.

1. The HBS coordinates care through an SCM or LCC for Qualified Individuals in a Care Plan who need considerable support at home, sometimes on a prolonged basis. Services provided may include a home health aide, psycho-social services and other behavioral health services as well as medication management and support in activities of daily living. If such services are needed, they are provided following a home-based assessment by an HCC and become part of the overall plan of care maintained by the LCC or SCM responsible for the Qualified Individual.

2. The need for a Home-Based Care Management Plan is determined by the CareFirst SCM or LCC, working under the direction of the Qualified Individual's

treating physician or nurse practitioner. Benefits will be provided for the HBS when the Qualified Individual is specifically referred to the HBS by a SCM or an LCC for full assessment and integrated home-based services pursuant to a Home-Based Care Management Plan. To be eligible for the HBS, the Qualified Individual must have a home-based assessment performed and completed by a Designated Provider.

A person is deemed to be in a Home-Based Care Management Plan only after the home-based assessment is completed and the plan is subsequently approved by the Qualified Individual's treating physician or nurse practitioner and the CareFirst SCM or LCC.

3. To maintain participation in the HBS, the Qualified Individual must:

   a) Participate fully with the Care Plan and Home-Based Care Management Plan as determined by CareFirst and the Qualified Individual's treating physician or nurse practitioner; and,

   b) Engage in regular communication with the HCC, LCC and/or SCM.

4. Covered Services rendered to the Qualified Individual provided through or as a result of the Home-Based Care Management Plan will not count toward any visit limits stated in the Schedule of Benefits.

13.3 Termination of the Chronic Care Coordination Program, Complex Case Management, Comprehensive Medication Review, Enhanced Monitoring Program, and Home Based Services Program.

A. The Qualified Individual's participation in the CCM, CCP, CMR, EMP, or HBS will be terminated under the following circumstances:

1. Upon completion of the stated goals of the CCM, CCP, CMR, EMP, or HBS as stated in the treatment plan, Care Plan or the Home-Based Care Management Plan and confirmed by the Qualified Individual's treating physician or nurse practitioner, the applicable program will be terminated and the Qualified Individual will no longer be eligible for benefits under the terminated program.

2. When the Qualified Individual fails to comply with the treatment plan of the CCM, CCP, CMR, or EMP or the Home-Based Care Management Plan of the HBS as determined by the CCC, HCC, LCC and/or SCM, as applicable, and the determination is approved by the Qualified Individual's treating physician or nurse practitioner.

3. Termination of the coverage of the Qualified Individual under the Evidence of Coverage.

B. The Qualified Individual will be given written notice thirty (30) days in advance of the termination date. If termination of the CCM, CCP, CMR, EMP, or HBS is the result of the Qualified Individual's failure to comply with the CCM, CCP, CMR, EMP, or HBS, the Qualified Individual will be provided the opportunity to comply with the CCM, CCP, CMR, EMP, or HBS during the thirty (30) days prior to the termination of the applicable program(s).

If after continued non-compliance during the thirty (30) day period and a consultation between the Qualified Individual's treating physician or nurse practitioner and the CCC, HCC, LCC and/or SCM, a determination is made that the Qualified Individual is not and will not be compliant with the applicable program(s), the Qualified Individual will receive a final written notice of termination of the applicable program(s).

C. Upon termination of the applicable program(s), any Covered Services for which there was no Member cost-sharing under the applicable program(s) will be subject to the applicable Deductible, Copayment or Coinsurance. This includes the Qualified

Individual's cost-sharing responsibilities for services provided in the home under the EMP (the Member would be responsible for any Durable Medical Equipment) and HBS (the Member would be responsible for Home Health Services as well as any additional services that were included in the Home-Based Care Management Plan).

13.4 Exclusions and Limitations. Coverage will not be provided for the services listed in this provision when rendered by non-Designated Providers unless the service is provided pursuant to a Home Based Care Management Plan under provision 13.2F.

SECTION 14
GENERAL PROVISIONS

14.1 How the Plan Works**.** The Preferred Provider Plan offers two levels of benefits. A Member may select the benefit level at which coverage will be provided each time care is sought. Under the Preferred Provider Plan, the Member may receive benefits for a particular service under either the in-network component or the out-of-network component. A Member may not receive duplicate benefits for the same services.

A. In-Network Benefits. When in-network benefits apply, Members are eligible for a higher level of benefits than when a provider other than those stated in this Section is used. In-network benefits apply in the following instances:

1. Services Rendered by a Preferred Provider, Preferred Dentist, Contracting Pharmacy Provider or Contracting Vision Provider. When Members use a Preferred Provider, Preferred Dentist, Contracting Pharmacy Provider or Contracting Vision Provider, benefits are based on the Allowed Benefit for that type of service. The level of benefits is reflected in the Schedule of Benefits. A Preferred Provider, Preferred Dentist, Contracting Pharmacy Provider or Contracting Vision Provider will submit claims directly to CareFirst for Covered Services, Covered Dental Services and Covered Vision Services.

2. Referral to a Specialist or Non-Physician Specialist. A Member may request a referral to a Specialist or Non-Physician Specialist who is a Non-Preferred Provider if the Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and,

   a) CareFirst does not contract with a Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or,

   b) CareFirst cannot provide reasonable access to a Preferred Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

   For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, CareFirst will treat the services rendered by the Non-Preferred Specialist or Non-Physician Specialist as if the service was provided by a Preferred Provider. The Member is responsible for the difference between the Allowed Benefit and the charge by a Non-Preferred Specialist or Non-Physician Specialist.

   A decision by CareFirst not to provide access to or coverage of treatment or health care services by a Specialist or Non-Physician Specialist as stated in this provision constitutes an adverse decision if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

B. Out-of-Network Benefits.

1. Except for Emergency Services, out-of-network benefits apply when Covered Services, Covered Dental Services or Covered Vision Services are provided by a Non-Preferred Provider, Non-Preferred Dentist, Non-Contracting Vision Provider or non-Contracting Pharmacy Provider or in a circumstance not addressed in Section 14.1A or 14.3E. When a Member uses a provider that is not a Preferred Provider, Preferred Dentist, Contracting Pharmacy Provider or Contracting Vision Provider, benefits are based on the appropriate Allowed Benefit. The level of benefits is shown in the Schedule of Benefits. The Member will be responsible for any applicable Deductible, Copayments or

Coinsurance. Except for Covered Dental Services rendered by a Participating Dentist or if the Member makes an Assignment of Benefits for services rendered by a Non-Preferred Provider who is a physician and who is a Hospital-Based Physician, an On-Call Physician, or by an Ambulance Service Provider, the Member will be responsible for any Balance Bill from a Non-Preferred Provider, a Non-Participating Dentist, a Non-Contracting Vision Provider or a non-Contracting Pharmacy Provider unless the fee is negotiated. If the fee is negotiated the Member will not be responsible for any Balance Bill.

2. Member Responsibilities.

a) Members are required to submit claims for Covered Services, Covered Dental Services and Covered Vision Services rendered by Non-Preferred Providers, Non-Participating Dentists Non-Contracting Vision Providers and non-Contracting Pharmacy Providers . Members may have claims submitted by a Non-Preferred Provider, a Non-Participating Dentist a Non- Contracting Vision Provider or a non-Contracting Pharmacy Provider on their behalf. A claim submitted by a Non-Preferred Provider, Non-Participating Dentist, and Non- Contracting Vision Provider on behalf of a Member must be submitted within the time frame granted to the Member to file the claim. Refer to Section 6.2 of the Evidence of Coverage for claims submission requirements and Section 6.3 of the Evidence of Coverage for the Member's ability to make an Assignment of Benefits to certain providers.

b) Members are responsible for making arrangements with CareFirst to obtain prior authorization, utilization management authorizations and approvals required for Covered Services and Covered Vision Services received from Non-Preferred Providers, Non- Contracting Vision Providers or non-Contracting Pharmacy Providers. See Section 15, Utilization Management, for the services that require prior authorization. As stated in Section 14.3F, the Member is required in all circumstances to obtain and submit to CareFirst the required pre-treatment estimate for orthodontic services obtained from a Preferred Dentist, a Participating Dentist or a Non-Participating Dentist.

14.2 Limitation on Provider Coverage. Services are covered only if the provider is an Eligible Provider. Eligible Provider means a provider who is licensed, or otherwise authorized by law, in the jurisdiction where the services are rendered. In addition, to be covered, the services must be within the lawful scope of the services for which that provider is licensed or otherwise authorized by law. Coverage does not include services rendered to Members by:

A. An individual who is not an Eligible Provider; or,

B. The Member himself/herself, or by the Member's Spouse, mother, father, daughter, son, brother, or sister.

14.3 Pediatric Dental Coverage.

A. The pediatric dental coverage offers the Member a choice of Dentists: Preferred Dentists and Non-Preferred Dentists. Payment depends on the Dentist chosen, as described in the Schedule of Benefits.

B. If a conflict arises regarding the quality and extent of work related to any Covered Dental Service, the case in question will be submitted to the CareFirst Dental Director for resolution. See Benefit Determination and Appeal and Grievance Procedures.

C. Benefits for Covered Dental Services rendered by Preferred Dentists will be provided by CareFirst as stated in the Schedule of Benefits. Benefits for Covered Dental Services rendered by Participating Dentists and Non-Participating Dentists will be provided by CareFirst as stated in the Schedule of Benefits for Non-Preferred Providers. The date a

service is received or the date supplies are purchased will be the date such expenses are incurred.

D. Member/Provider Relationship.

1. The Member has the exclusive right to choose a Dentist. Whether a Dentist is a Preferred Dentist or Non-Preferred Dentist relates only to method of payment, and does not imply that any Dentist is more or less qualified than another.

2. CareFirst makes payment for Covered Dental Services, but does not provide these services. CareFirst is not liable for any act or omission of any Dentist.

E. Referral to a Participating Dental Specialist and Non-Participating Dental Specialist.

A Dental Specialist is a Dentist who is certified or trained in a specified field of dentistry. A Member may request a referral to a Dental Specialist who is a Participating Dentist or Non-Participating Dentist if the Member is diagnosed with a condition or disease that requires specialized dental care; and

1. CareFirst does not contract with a Preferred Dentist who is a Dental Specialist with the professional training and expertise to treat the condition or disease; or,

2. CareFirst cannot provide reasonable access to a Preferred Dentist who is a Dental Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

For purposes of calculating any Coinsurance payable by the Member, CareFirst will treat the services rendered by the Dental Specialist as if the services were provided by a Preferred Dentist who is a Dental Specialist. The Member is not responsible for the difference between the Pediatric Dental Allowed Benefit and the charge by a Non-Participating Dental Specialist to whom the Member has been referred.

A decision by CareFirst not to provide access to or coverage of treatment by a Dental Specialist within this section constitutes an Adverse Decision if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

F. Estimate of Eligible Benefits. A Dentist may propose a planned dental treatment or series of dental procedures. A Member may choose to obtain a written estimate of the benefits available for such procedure(s).

CareFirst encourages a Member to obtain a written Estimate of Eligible Benefits (CareFirst's written estimate of benefits before a service is rendered) also known as a pre-treatment estimate (PTE) for major dental procedures, thereby alerting a Member of the out-of-pocket expenses that may be associated with the treatment plan, related deductibles, co-insurance and/or procedures that are not Covered Dental Services. Based on an Estimate of Eligible Benefits or PTE from CareFirst, a Member can decide whether or not to incur the expense that may be associated with a particular treatment plan.

Failure to obtain an Estimate of Eligible Benefits or PTE has no effect on the benefits to which a Member is entitled under this Evidence of Coverage, except for orthodontic services. A Member may choose to forgo the Estimate of Eligible Benefits or PTE and proceed with treatment, unless orthodontic services are planned. The process for orthodontic services is described below.

After the services are rendered, the claim will be reviewed by CareFirst. Should the review determine that the service(s) rendered meet CareFirst's criteria for benefits, the benefits will be provided as described in this Evidence of Coverage. However, should the review of the claim determine that the treatment or procedure(s) did not meet CareFirst's criteria for benefits, benefits will not be provided.

To request an Estimate of Eligible Benefits or PTE prior to receiving dental treatment or

dental procedures, a Member should contact his or her Dentist who will coordinate the request on the Member's behalf. If the Dentist has any questions about the process, he or she may contact the CareFirst Provider Services Department or go to the CareFirst website at www.carefirst.com, which lists information in the Physicians and Providers section, under the subsection for Dental, and list of Resources. The Estimate of Eligible Benefits or PTE is merely an estimate, and it cannot be considered a guarantee of the Member's benefits or enrollment under this Evidence of Coverage.

The process is different for orthodontic services. The Affordable Care Act requires that orthodontics must be Medically Necessary to be Covered Dental Services. To request a PTE for orthodontic services, the Member must see an orthodontist who will do an exam and orthodontic assessment that may include taking orthodontic records (study models and certain x-rays). The orthodontist will then complete a case assessment using a scoring tool required by the state. Then the orthodontic records and case assessment will be sent to CareFirst for evaluation and confirmation of the assessment score. If the score meets or exceeds the baseline requirement, the orthodontics will be approved for the Member. If the score is less than the minimal required score, then the request for orthodontic benefits will be denied.

A decision by CareFirst to deny benefits as described in this section constitutes an Adverse Decision as defined in the Evidence of Coverage if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

14.4 Pediatric Vision Coverage.

A. When the Member receives a vision examination and Low Vision services from a Contracting Vision Provider, the benefit payment is accepted as payment in full.

B. When a Member receives collection frames and basic spectacle lenses or collection contact lenses from a Contracting Vision Provider, the Member's responsibility is as stated below. The benefit payment is as stated in the attached Schedule of Benefits.

1. When the Member obtains frames from the display of collection frames (the collection designated by the Vision Care Designee) and basic spectacle lenses from a Contracting Vision Provider, the benefit payment is accepted as payment in full. When the Member obtains collection contact lenses (those contact lenses designated by the Vision Care Designee) from a Contracting Vision Provider, the benefit payment is accepted as payment in full.

2. Add-ons to basic spectacle lenses, non-collection frames and non-collection contact lenses are not covered under this Evidence of Coverage when obtained from a Contracting Vision Provider.

3. Medically Necessary Contact Lenses are covered. When Medically Necessary Contact Lenses are obtained from a Contracting Vision Provider. the benefit payment is accepted as payment in full.

C. When the Member receives Covered Vision Services from a Non-Contracting Vision Provider, charges above the Pediatric Vision Allowed Benefit are a non-Covered Vision Service. Add-ons to basic spectacle lenses are not covered under this Evidence of Coverage when received from a Non-Contracting Vision Provider. The Member is responsible for obtaining prior authorization for Medically Necessary Contact Lenses and Low Vision Services by calling the Vision Care Designee at the telephone number on the Member's identification card.

D. Limited Access Area: If the Member resides in an area that does not have adequate access to a Contracting Vision Provider and the Member receives Covered Vision Services from a Non-Contracting Vision Provider, the Vision Care Designee will pay up to 100% of the Allowed Benefit. The Member is responsible for any difference between the amount billed and the Vision Care Designee's payment. To determine if the Member

resides in a limited access area, the Member must call the Vision Care Designee at the telephone number on the Member's identification card.

14.5 Prescription Drug Coverage.

A. Accessing the Prescription Drug Benefit Card Program.

1. Members may use his/her identification card to purchase Prescription Drugs from Contracting Pharmacy Providers. If the Prescription Drug coverage includes a Deductible, the Member must pay the entire cost of the Prescription Drug(s) until the Deductible is satisfied. Once the Deductible, if applicable, has been satisfied, the Member pays the appropriate Copayment or Coinsurance as stated in the Schedule of Benefits.

2. For Prescription Drugs or diabetic supplies purchased from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. In cases of Emergency Services, Members will be entitled to reimbursement from CareFirst or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance. In all other cases, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and for any Balance Bill.

3. Members have the option of ordering Prescription Drugs via mail order. The mail order program provides its Member's with a Contracting Pharmacy Provider that has an agreement with CareFirst or its designee, to provide mail service Prescription Drugs in accordance with the terms of this provision. The Member is responsible for any applicable Deductible and Copayment or Coinsurance.

B. Additional Terms and Conditions.

1. Members or health care providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Prescription Drug on the Prior Authorization List. A copy of the Prior Authorization List is available to the Member or provider upon request.

2. Providers may substitute a Generic Drug for a Brand Name Drug. If there is no Generic Drug for the Brand Name Drug the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits for Preferred Brand Name Drugs or Non-Preferred Brand Name Drugs.

3. If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug.

4. Members must use 70% of a dispensed non-Maintenance Drug or Maintenance Drug in the manner prescribed before a refill of that prescription can be obtained.

Coverage for a refill of prescription eye drops shall be provided in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid Services; and, if:

a. the prescribing health care practitioner indicates on the original prescription that additional quantities of the prescription eye drops are needed;

b. the refill requested by the Member does not exceed the number of additional quantities indicated on the original prescription by the prescribing health care practitioner; and,

c. the prescription eye drops prescribed by the health care practitioner are a covered benefit under the Evidence of Coverage.

5. The Member is responsible for obtaining prior authorization for Prescription Drugs on the Prior Authorization List when obtained from a Non-Contracting Pharmacy Provider by calling the customer service telephone number listed on the identification card.

14.6 Payment Practices for Multiple Provider Participation in a Surgical Procedure. If a surgical procedure is performed by two or more surgeons, CareFirst will review the procedures to determine the benefits provided and apply all applicable reimbursement policies, as follows:

A. If the procedure is a Team Surgery, CareFirst will determine and provide the percentage of the Allowed Benefit for the surgical procedure apportioned to each surgeon of the team. This apportionment is based on several factors, including, but not limited to: the complexity of the individual surgical services performed; the amount of involvement in the operating room; the amount of pre- and post-operative care required; and whether the procedures performed are related or incidental to each other.

B. If the procedure is a Co-Surgery, the Allowed Benefit for the surgical procedure is divided equally between the co-surgeons participating in the Co-Surgery.

C. If the procedure requires a Surgical Assistant, the Allowed Benefit for Surgical Assistant services is an amount equal to 20% of the Allowed Benefit for the Covered Services provided by the operating surgeon(s) for a single procedure, and 10% of the Allowed Benefit for the Covered Services for each subsequent procedure.

1. Benefits are provided for surgical assistance performed by a physician assistant, registered nurse first assistant, nurse midwife, or nurse practitioner who is employed by the billing surgeon or directly contracted with CareFirst. Benefits are not provided for surgical assistance performed by unlicensed individuals, including but not limited to, surgical technicians and certified surgical assistants.

2. Benefits are not provided for surgical assistance performed by physician assistants, registered nurse first assistants, nurse midwives, or nurse practitioners who are employed by a facility. Benefits are not provided for surgical assistance directly to physician assistants or registered nurse first assistants.

SECTION 15
UTILIZATION MANAGEMENT REQUIREMENTS

Failure to meet the requirements of the Utilization Management Program may result in a reduction or denial of benefits even if the services are Medically Necessary. Prior authorization from CareFirst will be obtained by Preferred Providers, Contracting Vision Providers and Contracting Pharmacy Providers located in the CareFirst Service Area. For the Covered Services listed in Section 15.5, it is the Member's responsibility to obtain prior authorization when services are rendered outside of the CareFirst Service Area and for services rendered by Non-Preferred Providers, Non-Contracting Vision Providers or non-Contracting Pharmacy Providers. The Member is also responsible to obtain and submit to CareFirst the required pre-treatment estimate (PTE) for orthodontic services stated in Section 14.3F when those services are rendered by a Preferred Dentist, a Participating Dentist or a Non-Participating Dentist.

15.1 Utilization Management. Benefits are subject to review and approval under utilization management requirements established by CareFirst. Through utilization management, CareFirst will:

A. Review Member care and evaluate requests for approval of coverage in order to determine the Medical Necessity for the services;

B. Review the appropriateness of the hospital or facility requested; and,

C. Determine the approved length of confinement or course of treatment in accordance with CareFirst established criteria.

In addition, utilization management may include additional aspects such as prior authorization, and/or preadmission testing requirements, concurrent review, and discharge planning. Failure or refusal of the Member to comply with notice requirements and other utilization management authorization and approval procedures may result in a significant reduction in or exclusion of benefits. If coverage is reduced or excluded for failure to comply with utilization management requirements, the reduction or exclusion may be applied to all services (other than Medically Necessary inpatient Ancillary Services) related to the treatment, admission, or portion of the admission for which utilization management requirements were not met. The terms that apply to a Member's coverage for failure to comply with utilization management requirements are stated in the Schedule of Benefits.

15.2 Preferred Provider Responsibility. Prior authorization will be obtained by Preferred Providers, Contracting Vision Providers and Contracting Pharmacy Providers. These providers are also responsible for providing utilization management notices and obtaining necessary utilization management approvals on the Member's behalf for services that require prior authorization. However, the Member must advise the Preferred Provider that such coverage exists. If the Preferred Provider, Contracting Vision Provider or Contracting Pharmacy Provider fails to obtain prior authorization, the Member shall be held harmless.

In all other instances, the Member must comply with utilization management requirements and determinations, such as concurrent care and discharge planning. Refusal to follow these requirements may result in coverage being reduced or excluded.

15.3 Member Responsibility. If the Member receives Covered Services or Covered Vision Services outside of the Service Area or care is rendered by a Non-Preferred Provider, Non-Contracting Vision Provider or non-Contracting Pharmacy Provider, the Member is responsible for obtaining all required prior authorizations. As stated in Section 14.3F, the Member is also required to obtain and submit to CareFirst the required pre-treatment estimate for orthodontic services obtained from a Preferred Dentist, a Participating Dentist or a Non-Participating Dentist. It is the Member's responsibility to ensure that providers associated with the Member's care cooperate with utilization management requirements. This includes initial notification in a timely manner, responding to CareFirst inquiries and, if requested, allowing CareFirst representatives to review medical records on-site or in CareFirst offices. If CareFirst is unable to conduct utilization reviews, Member benefits may be reduced or excluded from coverage.

See Section 15.5 for Covered Services and Covered Vision Services for which the Member must obtain prior authorization. See Section 14.3F for orthodontic services that require a pre-treatment estimate (PTE).

15.4 Procedures. To initiate utilization management review, the Member may directly contact CareFirst or may arrange to have notification given by a family member or by the provider that is involved in the Member's care. However, these individuals will be deemed to be acting on the Member's behalf. If the Member and/or the Member's representatives fail to contact CareFirst as required or provide inaccurate or incomplete information, benefits may be reduced or excluded.

Members should share the utilization management requirements with family members and other responsible persons who could arrange for care on the Member's behalf in accordance with these provisions in case the Member is unable to do so when necessary. CareFirst will provide additional information regarding utilization management requirements and procedures, including telephone numbers and hours of operation, at the time of enrollment and at any time upon the Member's request.

15.5 Services Subject to Utilization Management. Preferred Providers, Contracting Vision Providers and Contracting Pharmacy Providers are responsible for obtaining necessary utilization management approvals on the Member's behalf for services that require prior authorization. It is the Member's responsibility to obtain prior authorization when services are rendered outside of the CareFirst Service Area and for services rendered by Non-Preferred Providers, Non-Contracting Vision Providers or non-Contracting Pharmacy Providers.

A. Hospital Inpatient Services. All hospitalizations (except for maternity and Emergency admissions as specified) require prior authorization. The Member must contact CareFirst (or have the provider contact CareFirst) at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because it is not feasible to delay the admission for five (5) business days due to the Member's medical condition, CareFirst must receive notification of the admission as soon as possible but in any event within forty-eight (48) hours following the beginning of the admission or by the end of the first business day following the beginning of the admission, whichever is later. Note the following:

1. Ancillary Services. Benefits for inpatient Ancillary Services will not be denied solely based on the fact that the denial of the hospitalization day was appropriate. Instead, a denial of inpatient Ancillary Services shall be based on the Medical Necessity of the specific Ancillary Service. In determining the Medical Necessity of an Ancillary Service performed on a denied hospitalization day, consideration shall be given to the necessity of providing the Ancillary Service in the acute setting for each day in question.

2. For emergency admissions, CareFirst may not render an adverse decision solely because CareFirst was not notified of the emergency admission within the prescribed period of time after that admission if the Member's condition prevented the hospital from determining the Member's insurance status or CareFirst's emergency admission requirements.

B. Inpatient Mental Health and Substance Abuse Services. The Member must contact CareFirst (or have the provider contact CareFirst) at least five (5) business days prior to an elective or scheduled admission. If the admission cannot be scheduled in advance because care is required immediately due to the Member's condition, CareFirst must receive notification of the admission as soon as possible but in any event within forty-eight (48) hours following the beginning of the admission or by the end of the first business day following the beginning of the admission, whichever is later.

For emergency admissions, CareFirst may not render an adverse decision solely because CareFirst was not notified of the emergency admission within the prescribed period of time after that admission if the Member's condition prevented the hospital from determining the Member's insurance status or CareFirst's emergency admission requirements.

In the case of an inpatient mental health and/or substance abuse admission of a Member who is determined by the Member's physician or psychologist, in conjunction with a member of the hospital staff who has admitting privileges, to be in imminent danger to himself/herself or others, CareFirst may not render an adverse authorization determination for an involuntary admission until seventy-two (72) hours after the admission.

C. Organ and Tissue Transplants. Transplants and related services must be coordinated and prior authorization must be obtained from CareFirst. Prior authorization is not required for cornea and kidney transplants. Coverage for related medications is available under Section 11, Prescription Drugs.

D. Ambulance Services. Prior authorization is required for air ambulance services only, except for Medically Necessary air ambulance services in an emergency.

E. Other Services. If the Member requires any of the following services, the Member must contact CareFirst (or have the physician, hospital, or other provider contact CareFirst) at least five (5) business days prior to the anticipated date upon which the elective admission or treatment will commence:

1. Home Health Care Services, except Home Health Visits following a Mastectomy and surgical removal of a testicle post-partum Home Health Visits;
2. Skilled Nursing Facility Services;
3. Hospice Care Services;
4. Habilitative Services;
5. Controlled Clinical Trials;
6. General Anesthesia for Dental Care;
7. Inpatient Residential Treatment Center Facility Services.
8. Low Vision Services and Medically Necessary Contact Lenses; and,
9. Prescription Drugs on the Prior Authorization List and human growth hormones.

Covered Services not listed in Section 15.5 do not require prior authorization. CareFirst reserves the right to make changes to the categories of services that are subject to utilization management requirements or to the procedures the Member and/or the providers must follow. CareFirst will notify the Member of these changes at least forty-five (45) days in advance.

15.6 Medicare as Primary. Prior authorization is not required for any Covered Services when Medicare is the primary insurer.

15.7 Concurrent Review and Discharge Planning. Following timely notification, CareFirst will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment.

15.8 Appealing a Utilization Management Decision. If the Member, the Member's representative or Member's provider disagrees with a utilization management decision, CareFirst will review the decision upon request. A utilization management appeal will be reviewed and decided upon by the CareFirst Medical Director or Associate Medical Director not involved in the initial denial decision. If necessary, the Medical Director or Associate Medical Director will discuss the Member's case with the Member's physician and/or request the opinion of a Specialist board certified in the same specialty as the treatment under review. Any non-certification or penalty may be appealed. Additional information is provided in the Benefit Determination and Appeal and Grievance Procedures section on how to appeal a utilization management decision.

SECTION 16
EXCLUSIONS AND LIMITATIONS

The following exclusions apply:

16.1 Services or supplies that are determined by CareFirst to be not Medically Necessary.

Payment for inpatient Ancillary Services may not be denied solely based on the fact that the denial of the hospitalization day was appropriate. A denial of inpatient ancillary services must be based on the Medical Necessity of the specific Ancillary Service. In determining the Medical Necessity of an Ancillary Service performed on a denied hospitalization day, consideration must be given to the necessity of providing the Ancillary Service in the acute setting for each day in question.

16.2 Services performed or prescribed under the direction of a person who is not a health care practitioner.

16.3 Services that are beyond the scope of practice of the health care practitioner performing the service.

16.4 Services to the extent they are covered by any governmental unit, except for veterans in Veteran's Administration or armed forces facilities for services received for which the recipient is liable.

16.5 Services or supplies for which the Member is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.

16.6 Except as provided in Section 3and for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury, the purchase, examination, or fitting of eyeglasses or contact lenses.

16.7 Personal Care services and Domiciliary Care services.

16.8 Services rendered by a health care practitioner who is the Member's spouse, mother, father, daughter, son, brother or sister.

16.9 Experimental/Investigational services.

16.10 Health care practitioner, hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery that involve corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

16.11 In vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.

16.12 Services to reverse a voluntary sterilization procedure.

16.13 Services for sterilization or reverse sterilization for a Dependent minor. This exclusion does not apply to FDA-approved sterilization procedures for women with reproductive capacity.

16.14 Medical or surgical treatment for obesity, unless otherwise specified under Section 1.3G and Section 1.22.

16.15 Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified herein.

16.16 Services incurred before the effective date of the Member's coverage.

16.17 Services incurred after the Member's termination of coverage, not including any services rendered during any extension of benefits period.

16.18 Surgery or related services for Cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital, or developmental anomalies.

16.19 Services for injuries or diseases related to the Member's job to the extent the Member is required to be covered by a workers' compensation law.

16.20 Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

16.21 Personal hygiene and Convenience Items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.

16.22 Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.

16.23 Inpatient admissions primarily for diagnostic studies, unless authorized by CareFirst.

16.24 The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as provided in Section 10.1D, hearing aids for Member from birth to age 18.

16.25 Except for covered ambulance services and travel benefits for a transplant recipient and companion(s) as stated in Section 4.3B, travel, whether or not recommended by a health care practitioner.

16.26 Except for Emergency Services, services received while outside the United States.

16.27 Immunizations related to foreign travel.

16.28 Unless otherwise specified herein, dental work or treatment which includes hospital or professional care in connection with:

A. The operation or treatment for the fitting or wearing of dentures;

B. Orthodontic care or malocclusion;

C. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within six months of the accident; and

D. Dental implants.

16.29 Except for Members under the age of 19, accidents occurring while and as a result of chewing.

16.30 Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary.

16.31 Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports or exams for his/her prescription or fitting unless these services or supplies are determined to be Medically Necessary.

16.32 Inpatient admissions primarily for physical therapy, unless authorized by CareFirst.

16.33 Treatment leading to or in connection with transsexualism, or sex changes or modifications, including, but not limited to surgery.

16.34 Treatment of sexual dysfunction not related to organic disease.

16.35 Services or supplies that duplicate benefits provided under federal, State, or local laws, regulations, or programs.

16.36 Non-human organs and its implantation.

16.37 Non-replacement fees for blood and blood products.

16.38 Lifestyle improvements, nutrition counseling, or physical fitness programs unless included as a Covered Service.

16.39 Wigs or cranial prostheses.

16.40 Weekend admission charges, except for Emergency Services and maternity, unless authorized by CareFirst.

16.41 Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.

16.42 Except as provided in Section 2, Pediatric Dental Services, temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.

16.43 Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

16.44 Services for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.

16.45 Services for, or related to, the removal of an organ from a Member for purposes of transplantation into another person unless the transplant recipient is covered under this Evidence of Coverage and is undergoing a covered transplant, and the services are not payable by another health plan.

16.46 Physical examinations required for obtaining or continuing employment, insurance, or government licensing.

16.47 Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

16.48 Private hospital room, unless authorized by CareFirst.

16.49 Private duty nursing, unless authorized by CareFirst.

16.50 Inpatient and Outpatient Mental Health and Substance Abuse Services. Benefits will not be provided for the following:

A. Services provided by pastoral or marital counselors;

B. Therapy for sexual problems;

C. Treatment for learning disabilities and intellectual disabilities;

D. Telephone therapy;

E. Travel time to the Member's home to conduct therapy;

F. Services rendered or billed by schools, or halfway houses or members of his/her staffs;

G. Marriage counseling.

16.51 Benefits will not be provided for maintenance programs for Cardiac Rehabilitation or pulmonary rehabilitation.

Maintenance programs consist of activities that preserve the Member's present level of function and

prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

16.52 Any claim, bill, or other demand or request for payment for health care services determined to be furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.

16.53 Pediatric Dental Services.

A. Limitations.

1. Covered Dental Services must be performed by or under the supervision of a Dentist, within the scope of practice for which licensure or certification has been obtained.

2. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures, including precision attachments and custom denture teeth.

3. If a Member switches from one Dentist to another during a course of treatment, or if more than one Dentist renders services for one dental procedure, CareFirst shall pay as if only one Dentist rendered the service.

4. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to covered orthodontic services).

5. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative.

6. Benefits for radiographs are limited to radiographs required for proper treatment and/or diagnosis. Benefits for some or multiple radiographs of the same tooth or area may be denied if CareFirst determines the number to be redundant, excessive, or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the Allowed Benefit for a full month series.

7. When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the Allowed Benefit is limited to that of a one-surface restoration. Any charges in excess of the Allowed Benefit for the one-surface restoration are not Covered Dental Services.

B. Exclusions. Benefits will not be provided for:

1. Any dental service stated in Section 2 for Members over age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Dental Services through the rest of that Calendar Year.

2. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under this Evidence of Coverage or under any dental insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.

3. Any service, supply, or procedure that is not specifically listed as Covered Dental Services (even if Medically Necessary) or that do not meet all other conditions and criteria for coverage as determined by CareFirst.

4. Replacement of a denture or crown as a result of loss or theft.

5. Replacement of an existing denture or crown that is determined by CareFirst to be satisfactory or repairable.

6. Replacement of dentures or crowns within 60 months from the date of placement or replacement.

7. Gold foil fillings.

8. Periodontal appliances.

9. Splinting, except for intracoronal and extracoronal splinting.

10. Night guards or other oral orthotic appliances unless specifically listed as a Covered Dental Service.

11. Bacteriologic studies, histopathology exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service.

12. Intentional tooth reimplantation or transplantation, unless specifically listed as a Covered Dental Service and authorized by CareFirst.

13. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.

14. Tissue conditioning unless rendered prior to new denture impressions.

15. Additional fees charged for visits by a Dentist to the Member's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the Dentist's office during normal office hours.

16. Transseptal fiberotomy.

17. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service.

18. Any orthodontic services after the last day of the month in which Covered Dental Services ended except as specifically stated herein.

19. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be Covered Dental Services).

20. Separate billings for dental care services or supplies furnished by an employee of a Dentist which are normally included in the Dentist's charges and billed for by them.

21. Services that are beyond the scope of the license of the provider performing the service.

22. Bridges.

23. Dental implants and all services related to dental implants.

24. Adjustments to dentures made within six months of initial placement.

25. Rebase and/or reline denture within six months of initial placement and limited to one per 24 months after the six months following initial placement.

26. A preformed denture with teeth already mounted forming a denture module.

27. Crowns when received within 30 days of the date of service of a root canal or restoration on the same tooth.

28. Extraction of asymptomatic impacted teeth unless removal constitutes the most cost-effective dental procedure for the provision of dentures.

29. Unless otherwise stated in the Description of Covered Services, dentures solely for Cosmetic purposes.

30. Unless otherwise stated in the Description of Covered Services, orthodontic services solely for Cosmetic purposes.

31. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.

16.54 Pediatric Vision Services. Benefits will not be provided for the following:

A. Any pediatric vision service stated in Section 3 for Members over age 19. If the Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive covered pediatric vision services through the rest of that Calendar Year.

B. Diagnostic services, except as stated in Section 3. Benefits for treatment of medical conditions of the eye are covered under Section 1.

C. Services or supplies not specifically approved by the Vision Care Designee as required for Low Vision Services and Medically Necessary Contact Lenses.

D. Non-basic spectacle lenses, non-collection frames and non-collection contact lenses when obtained from a Contracting Vision Provider.

E. Orthoptics, vision training, and low vision aids, except as provided in Section 3.

F. Non-prescription (Plano) lenses and/or glasses, sunglasses or contact lenses.

G. Except as otherwise provided, Covered Vision Services that are strictly Cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

H. Any vision service, treatment, or materials not specifically listed as a Covered Service.

I. Services and materials not meeting accepted standards of optometric practice.

J. Services and materials resulting from the Member's failure to comply with professionally prescribed treatment.

K. Office infection control charges.

L. Charges for copies of the Member's records, charts, or any costs associated with forwarding or mailing copies of the Member's records or charts.

M. State or territorial taxes on vision services performed.

N. Special lens designs or coatings other than those described herein.

O. Replacement of lost and/or stolen eyewear.

P. Two pairs of eyeglasses in lieu of bifocals.

Q. Insurance of contact lenses.

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT C
SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Evidence of Coverage.

CareFirst pays only for Covered Services, Covered Dental Services and Covered Vision Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, Copayment or Coinsurance. Services that are not listed in the Description of Covered Services, or are listed in the Exclusions and Limitations, are not Covered Services, Covered Dental Services or Covered Vision Services.

When determining the benefits a Member may receive, CareFirst considers all provisions and limitations in the Evidence of Coverage as well as its medical policies. When these conditions of coverage are not met or followed, payments for benefits may be denied. Certain Utilization Management requirements will also apply. When these requirements are not met, payments may be reduced or denied.

GENERAL PROVISIONS	
DEDUCTIBLES	
IN-NETWORK DEDUCTIBLE	**OUT-OF-NETWORK DEDUCTIBLE**
The Individual Deductible is $250 per Benefit Period. The Family Deductible is $500 per Benefit Period.	The Individual Deductible is $500 per Benefit Period. The Family Deductible is $1,000 per Benefit Period.

IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES

Individual Coverage: The Member must satisfy the Individual Deductible.

Family Coverage: Each Member can satisfy his/her own Deductible by meeting the Individual Deductible. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Deductible. An individual family member may not contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible has been met, this will satisfy the Deductible for all covered family members.

The In-Network Deductible and the Out-of-Network Deductible are separate amounts and do not contribute to one another.

The following amounts may <u>not</u> be used to satisfy the In-Network OR Out-of-Network Deductibles:

- Amounts incurred for failure to comply with the Utilization Management Program requirements.
- Charges in excess of the Allowed Benefit.
- Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days listed below..
- Charges for Pediatric Vision Services or Pediatric Dental Services.

The benefit chart below states whether a covered service is subject to a Deductible. If a Deductible applies, the chart will also state whether a Deductible applies to In-Network benefits, Out-of-Network benefits, or both.

<table>
<tr><th colspan="2">OUT-OF-POCKET MAXIMUM</th></tr>
<tr><th>IN-NETWORK OUT-OF-POCKET MAXIMUM</th><th>OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM</th></tr>
<tr><td>The Individual Out-of-Pocket Maximum is $3,500 per Benefit Period.

The Family Out-of-Pocket Maximum is $7,000 per Benefit Period.

The following amounts apply to the In-Network Out-of-Pocket Maximum:
• Copayments for In-Network Covered Services.

• Coinsurance for covered In-Network services, including In-Network Pediatric Dental Services.

• The In-Network Deductible.

• The In-Network Pediatric Dental Deductible.

• Amounts paid toward In-Network Pediatric Vision Services.

• Amounts paid toward Prescription Drugs.

When the Member has reached the In-Network Out-of-Pocket Maximum, no further Copayments, Coinsurance, or Deductibles will be required in that Benefit Period for In-Network services.</td><td>The Individual Out-of-Pocket Maximum is $7,000 per Benefit Period.

The Family Out-of-Pocket Maximum is $14,000 per Benefit Period.

The following amounts apply to the Out-of-Network Out-of-Pocket Maximum:
• Copayments and Coinsurance for covered Out-of-Network services, including Out-of-Network Pediatric Dental Services. Amounts paid for Prescription Drugs obtained from a non-Contracting Pharmacy Provider will be applied to the In-Network Out-of-Pocket Maximum.

• The Out-of-Network Deductible.

• The Out-of-Network Pediatric Dental Deductible.

When the Member has reached the Out-of-Network Out-of-Pocket Maximum, no further Copayments, Coinsurance, or Deductibles will be required in that Benefit Period for Out-of-Network services.</td></tr>
<tr><th colspan="2">IN-NETWORK AND OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM</th></tr>
<tr><td colspan="2">Individual Coverage: The Member must meet the Individual Out-of-Pocket Maximum.
Family Coverage: Each Member can satisfy his/her own Out-of-Pocket Maximum by meeting the Individual Out-of-Pocket Maximum. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Out-of-Pocket Maximum. An individual family member may not contribute more than the Individual Out-of-Pocket Maximum toward meeting the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum has been met, this will satisfy the Out-of-Pocket Maximum for all covered family members.

The In-Network Out-of-Pocket Maximum and the Out-of-Network Out-of-Pocket Maximum are separate amounts and do not contribute to one another.

The following amounts may <u>not</u> be used to meet the In-Network or Out-of-Network Out-of-Pocket Maximum:
• Amounts incurred for failure to comply with the Utilization Management Program requirements.

• Difference between the price of a non-Preferred Brand Name Drug and Generic Drug when a Member selects a non-Preferred Brand Name Drug when a Generic Drug is available.

• Charges in excess of the Allowed Benefit.

• Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days listed below.

• Charges for Out-of-Network Covered Pediatric Vision Services.</td></tr>
<tr><th colspan="2">UTILIZATION MANAGEMENT</th></tr>
<tr><td colspan="2">Failure or refusal to comply with Utilization Management Program requirements will result in a 50% reduction in benefits for services associated with the Member's care or treatment. This reduction will not apply to Prescription Drugs and Pediatric Vision and Pediatric Dental benefits.</td></tr>
</table>

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider. Members who receive outpatient services, such as office visits, rehabilitative services, diagnostic testing, laboratory tests, and radiology (except for preventive, outpatient surgical, outpatient mental health and substance abuse, Emergency Services and Urgent Care services), in facilities within a hospital, hospital clinic, or health care provider's office on a hospital campus may be required to pay a separate Copayment or Coinsurance per visit to the hospital in addition to the professional Copayment or Coinsurance. These providers <u>may</u> bill individually resulting in claims from both the hospital/facility and the physician or health care provider rendering care in the hospital/facility/clinic setting. It is the Member's responsibility to determine whether separate claims will be assessed.				
Clinic Visits/ Outpatient Services rendered in a hospital, hospital clinic, or health care provider's office on a hospital campus	This payment may apply to any of the services listed within this Schedule of Benefits except for preventive, outpatient surgical, outpatient mental health and substance abuse, Emergency Services and Urgent Care services.	In-Network and Out-of-Network	$50 per visit	20% of the Allowed Benefit
OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES				
Physician's Office (including non-preventive diagnostic tests)		In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
Non-Preventive Laboratory Tests (independent non-hospital laboratory)		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Non-Preventive Radiologic Imaging (independent non-hospital facility)		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Other Non-Preventive Diagnostic Testing (except as otherwise specified in an independent non-hospital facility)		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Preventive Care - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society or required by the Patient Protection and Affordable Care Act (PPACA).				
Prostate Cancer Screening		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Colorectal Cancer Screening		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Breast Cancer Screening		No	No Copayment or Coinsurance	20% of the Allowed Benefit
Chlamydia Screening Test		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Human Papillomavirus Screening Test		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Preventive Diagnostic Testing (except as otherwise specified)		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Preventive Laboratory Tests		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Preventive Radiologic Imaging		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Immunizations		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Well Child Care (includes related lab tests and immunizations)		No	No Copayment or Coinsurance	20% of the Allowed Benefit
Adult Preventive Care (includes related services)		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Women's Preventive Services (includes related services)		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Osteoporosis Screening		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Preventive Services for Obesity		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Treatment Services				
Professional Nutritional Counseling and Medical Nutrition Therapy		In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
Family Planning				

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Non-Preventive Gynecological Care		In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
Contraceptive Counseling		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Contraceptive Drugs and Devices	Coverage of self-administered contraceptive drugs and devices is provided under the Prescription Drugs benefit.	Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs	Drug or device must be approved by the FDA as a contraceptive.	Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Elective Sterilization Services - Female Members	Benefits available to female Members with reproductive capacity, only.	Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Elective Sterilization Services - Male Members		In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
Maternity and Related Services				
Preventive Services		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Non-Preventive Services		In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
Professional Services for Delivery		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Professional Services for Nursery Care		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Infertility Treatment				
Infertility Counseling and Testing		In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
Artificial & Intrauterine Insemination	Limited to 6 attempts per live birth. Prior authorization is required.	In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
Allergy Services				
Allergy Testing and Treatment		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Allergy Shots		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Outpatient Rehabilitative Services				

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Rehabilitative Physical Therapy	Limited to 30 visits (per injury or illness) per Benefit Period. This limitation does not apply to Habilitative services for Children or Adults.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Rehabilitative Occupational Therapy	Limited to 30 visits (per injury or illness) per Benefit Period. This limitation does not apply to Habilitative services for Children or Adults.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Rehabilitative Speech Therapy	Limited to 30 visits (per injury or illness) per Benefit Period. This limitation does not apply to services for cleft lip and cleft palate or Habilitative services for Children or Adults.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Chiropractic Services	Limited to 20 visits per condition per Benefit Period.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Habilitative Services for Children	Limited to Members under the age of 19. Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Habilitative Services for Adults	Benefits available for Member age 19 and older. Limited to 30 visits (per injury or illness) per Benefit Period for Physical Therapy, 30 visits (per injury or illness) per Benefit Period for Occupational Therapy and 30 visits (per injury or illness) per Benefit Period for Speech Therapy. Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Acupuncture		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Cardiac Rehabilitation	Limited to 90 visits per therapy per Benefit Period.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Pulmonary Rehabilitation	Limited to one (1) pulmonary rehabilitation program per lifetime.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Other Treatment Services				
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation and pulmonary rehabilitation)		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Blood and Blood Products		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Controlled Clinical Trial	Prior authorization is required.	Benefits are available to the same extent as benefits provided for other services.		
General Anesthesia for Dental Care	Prior authorization is required.	Benefits are available to the same extent as benefits provided for other services.		
Accidental Dental Injury Services		Benefits are available to the same extent as benefits provided for other services.		
Services for the Treatment of Cleft Lip, Cleft Palate or Both		Benefits are available to the same extent as benefits provided for other services.		
Retail Health Clinic		In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
Outpatient Surgical Facility and Professional Services				
Surgical Care at an Outpatient Hospital Facility		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Surgical Care at an Ambulatory Care Facility		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Outpatient Surgical Professional Services Provided at an Outpatient Hospital or Ambulatory Care Facility	Preventive Colonoscopy is <u>not</u> subject to In-Network Deductible.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
INPATIENT HOSPITAL SERVICES				
Inpatient Facility (medical or surgical condition, including maternity and rehabilitation)	Prior authorization is required except for emergency admissions and all maternity admissions.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Inpatient Physician and Surgical Services (except for delivery services and nursery services under Maternity and Related Services)		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Organ and Tissue Transplants	Except for cornea transplants and kidney transplants, prior authorization is required.	Benefits are available to the same extent as benefits provided for other services.		
SKILLED NURSING FACILITY SERVICES				
Skilled Nursing Facility Services	Limited to 100 days per Benefit Period. Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
HOME HEALTH CARE SERVICES				
Home Health Services	Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Postpartum Home Visits	Benefits are available to all Members.	No	No Copayment or Coinsurance	No Copayment or Coinsurance
Home Visits Following a Mastectomy and Surgical Removal of a Testicle		In-Network and Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
HOSPICE SERVICES				
Inpatient Care	Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Outpatient Care	Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Respite Care	Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Bereavement Services	Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES				
Outpatient Services				
Office Visits		In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
Outpatient Hospital Facility Services		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Outpatient Professional Services Provided at an Outpatient Hospital Facility		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Outpatient Psychological and Neuro-psychological Testing for Diagnostic Purposes		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Medication Management		In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
Methadone Maintenance		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Partial Hospitalization		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Professional Services at a Partial Hospitalization Facility		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Inpatient Services				
Inpatient Facility Services	Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Inpatient Professional Services		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Inpatient Residential Treatment Center Services				
Inpatient Residential Treatment Center Facility Services	Prior authorization is required.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Inpatient Residential Treatment Center Professional Services		In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
EMERGENCY SERVICES AND URGENT CARE				
Urgent Care Facility	Limited to unexpected, urgently required services.	No	$10 per visit	$10 per visit
Hospital Emergency Room - Facility Services	Limited to Emergency Services or unexpected, urgently required services.	In-Network and Out-of-Network benefit subject to In-Network Deductible	$100 per visit, waived if admitted	$100 per visit, waived if admitted
Hospital Emergency Room - Professional Services	Limited to Emergency Services or unexpected, urgently required services.	In-Network and Out-of-Network benefit subject to In-Network Deductible	No Copayment or Coinsurance	No Copayment or Coinsurance
Emergency Transportation/ Ambulance	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency.	In-Network and Out-of-Network benefit subject to In-Network Deductible	No Copayment or Coinsurance	No Copayment or Coinsurance
MEDICAL DEVICES AND SUPPLIES				
Durable Medical Equipment		In-Network and Out-of-Network	25% of the Allowed Benefit	25% of the Allowed Benefit
Orthotic and Prosthetic Devices		In-Network and Out-of-Network	25% of the Allowed Benefit	25% of the Allowed Benefit
Medical Food for Members with Metabolic Disorders		In-Network and Out-of-Network	25% of the Allowed Benefit	25% of the Allowed Benefit
Breastfeeding Equipment and Supplies		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit

SERVICE	LIMITATIONS (Combined In and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Diabetes Equipment	Diabetic Supplies covered under Prescription Drugs.	In-Network and Out-of-Network	25% of the Allowed Benefit	25% of the Allowed Benefit
Hearing Aids for Minor Children				
Hearing Aids for Minor Children	Limited to one hearing aid for each hearing impaired ear every 36 months. Limited to Members who are minor children.	In-Network and Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Hearing Aid Related Services	Limited to Members who are minor children.	In-Network and Out-of-Network	$10 per visit	20% of the Allowed Benefit
WELLNESS BENEFIT				
Health Risk Assessment		No	No Copayment or Coinsurance	Not covered
Health Risk Assessment Feedback		No	No Copayment or Coinsurance	Not covered
COMPLEX CHRONIC OR HIGH RISK ACUTE DISEASE MANAGEMENT				
Associated Costs for the Patient-Centered Medical Home Program (PCMH)	Benefits will be provided as described in the Description of Covered Services for Patient-Centered Medical Home and Chronic Complex or High Risk Acute Disease Management.	No	No Copayment or Coinsurance	Not covered
Services Provided Pursuant to a Plan of Care	Benefits will be provided as described in the Description of Covered Services for Patient-Centered Medical Home and Chronic Complex or High Risk Acute Disease Management.	No	No Copayment or Coinsurance	Not covered
TCCI Program Elements	Benefits will be provided as described in the Description of Covered Services for Patient-Centered Medical Home and Chronic Complex or High Risk Acute Disease Management.	No	No Copayment or Coinsurance	Not covered

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a non-Preferred Brand Name Drug, and the Member selects the non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst. • Diabetic Supplies and oral chemotherapy drugs are not subject to the Copayment or Coinsurance. • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prior Authorization List.				
Prescription Drugs	Limited to a 34-day supply per prescription or refill.	No	**Preferred Preventive Drugs:** No Copayment or Coinsurance **Generic Drugs:** $10 per prescription **Preferred Brand Name Drugs:** $45 per prescription **Non-Preferred Brand Name Drugs:** $65 per prescription	
Maintenance Drugs	Limited to a 90-day supply per prescription or refill. Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.	No	**Preferred Preventive Drugs:** No Copayment or Coinsurance **Generic Drugs:** $20 per prescription **Preferred Brand Name Drugs:** $90 per prescription **Non-Preferred Brand Name Drugs:** $130 per prescription	
Specialty Drugs		No	**Specialty Drugs:** 50% of the Prescription Drug Allowed Benefit per prescription for up to a 34-day supply of a non-Maintenance Drug 50% of the Prescription Drug Allowed Benefit per prescription for up to a 90-day of a Maintenance Drug	

Pediatric Vision - Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year.				
SERVICE	**LIMITATIONS (Combined In and Out-of-Network)**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**	
			CONTRACTING VISION PROVIDER	**NON-CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $40
Lenses - Important note regarding Member Payments: "Basic" means spectacle lenses with no "add-ons" such as glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses and others which may result in additional costs to the Member.				
Basic Single vision	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $40
Basic Bifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $60
Basic Trifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $80
Basic Lenticular	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $100
Frames				
Frames	Limited to one frame per Benefit Period. Covered Vision Services rendered by Contracting Vision Providers limited to frames contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $70
Low Vision				
Low Vision Eye Examination	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider. Limited to one comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $300
Follow-up care	Prior authorization required	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of

Pediatric Vision - Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year.				
SERVICE	**LIMITATIONS (Combined In and Out-of-Network)**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**	
			CONTRACTING VISION PROVIDER	**NON-CONTRACTING VISION PROVIDER**
	It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider. Limited to four visits in any five-year period.			$100
High-power Spectacles, Magnifiers and Telescopes	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $600
Contact Lenses				
Elective	Includes evaluation, fitting and follow-up fees. Limited to one per Benefit Period. Covered Vision Services rendered by Contracting Vision Providers limited to contact lenses contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $105
Medically Necessary	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider. Limited to one per Benefit Period.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $225

Pediatric Dental - Limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Dental Services through the rest of that Calendar Year.	
Pediatric Dental Deductible	
The In-Network Deductible of $25 per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services.	The Out-of-Network Deductible of $50 per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services.
Pediatric Dental Out-of-Pocket Maximum	
Amounts paid by the Member for Covered Pediatric Dental Services will be applied to the Out-of-Pocket Maximum stated above. Once the Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible or Coinsurance.	

SERVICE	LIMITATIONS (Combined In-Network and Out-of-Network)	SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED DENTIST	NON-PREFERRED DENTIST
Class I Preventive & Diagnostic Services		No	No Coinsurance	20% of the Pediatric Dental Allowed Benefit
Class II Basic Services		Yes	20% of the Pediatric Dental Allowed Benefit	40% of the Pediatric Dental Allowed Benefit
Class III Major Services - Surgical		Yes	20% of the Pediatric Dental Allowed Benefit	40% of the Pediatric Dental Allowed Benefit
Class IV Major Services - Restorative		Yes	50% of the Pediatric Dental Allowed Benefit	65% of the Pediatric Dental Allowed Benefit
Class V Orthodontic Services	Limited to Members with severe, dysfunctional, handicapping malocclusion. A pre-treatment estimate (PTE) must be submitted to CareFirst, and CareFirst must approve the services. It is the Member's responsibility to obtain the pre-treatment estimate (PTE).	No	50% of the Pediatric Dental Allowed Benefit	65% of the Pediatric Dental Allowed Benefit

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer

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doing business as
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840 First Street, NE
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A not-for-profit health service plan

An independent licensee of the Blue Cross and Blue Shield Association

INTER-PLAN ARRANGEMENTS DISCLOSURE AMENDMENT

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

Out-of-Area Services.

CareFirst has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Evidence of Coverage are described generally below.

Typically, Members, when accessing care outside the geographic area CareFirst serves, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating/PPO providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. CareFirst payment practices in both instances are described below.

A. BlueCard® Program.

Under the BlueCard® Program, when Members access covered healthcare services from a provider within the geographic area served by a Host Blue, CareFirst will remain responsible to the Group for fulfilling CareFirst contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers, and providing some managed care services. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim.
The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program, if not a flat dollar copayment amount, will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to CareFirst by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to CareFirst by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

1. an actual price. An actual price is a negotiated payment without any other increases or decreases, or

2. an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

3. an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to CareFirst is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst would then calculate Member liability in accordance with the statutes of the State of Maryland.

Return of Overpayments.
Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. Recovery amounts determined in these ways will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

B. Non-Participating Healthcare Providers Outside the CareFirst Service Area.

1. Member Liability Calculation.

When covered healthcare services are provided outside of the CareFirst service area by non-participating healthcare providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by the laws of the State of Maryland. In these situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.
The Member will not be liable for this difference if the non-participating healthcare provider is a non-participating on-call physician who accepts an assignment of benefits.

2. Exceptions.

In some exception cases, CareFirst may pay claims from non-participating healthcare providers outside of the CareFirst service area based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a participating provider, as determined by CareFirst in its sole and absolute discretion or by applicable state law. In other exception cases, CareFirst may pay such a claim based on the payment it would make if CareFirst were paying a non-participating provider inside of the

CareFirst service area, as described elsewhere in this Evidence of Coverage, where the Host Blue's corresponding payment would be more than the CareFirst in-Service Area non-participating provider payment, or in CareFirst's sole and absolute discretion, CareFirst may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. The Member will not be liable for this difference if the non-participating healthcare provider is a non-participating on-call physician who accepts an assignment of benefits.

Inter-Plan Programs Eligibility Claim Types.
All claim types are eligible to be processed through the Inter-Plan Programs except for those Dental Care Benefits, Prescription Drug Benefits, or Vision Care Benefits that may be delivered by a third-party contracted by CareFirst to provide the specific service or services.

This amendment is issued to be attached to the Evidence of Coverage. This amendment does not change the terms and conditions of the Evidence of Coverage, unless specifically stated herein.

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President and Chief Executive Officer

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Out-of-Area Services.

CareFirst has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members obtain healthcare services outside of the CareFirst service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

Typically, when accessing care outside the CareFirst service area, Members will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating/PPO providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. CareFirst payment practices in both instances are described below.

A. BlueCard® Program.

Under the BlueCard® Program, when Members access covered healthcare services from a provider within the geographic area served by a Host Blue, CareFirst will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever a Member accesses covered healthcare services outside the CareFirst service area and the claim is processed through the BlueCard Program, the amount the Member pays for covered healthcare services is calculated based on the lower of:

- The billed covered charges for the Covered Services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

While this provision applies when the cost-sharing is coinsurance, it would not apply if the cost-sharing is a flat dollar copayment.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted

above. However, such adjustments will not affect the price CareFirst uses for a claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, CareFirst would then calculate Member liability for any covered healthcare services according to the laws of the State of Maryland.

Inter-Plan Programs Eligibility Claim Types.

All claim types are eligible to be processed through the Inter-Plan Programs except for those Dental Care Benefits, Prescription Drug Benefits, or Vision Care Benefits that may be delivered by a third-party contracted by CareFirst to provide the specific service or services.

B. Non-Participating Healthcare Providers Outside the CareFirst Service Area.

1. Member Liability Calculation.

   When covered healthcare services are provided outside of the CareFirst service area by non-participating healthcare providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by the laws of the State of Maryland. In these situations, the Member may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. The Member will not be liable for this difference if the non-participating healthcare provider is a non-participating on-call physician who accepts an assignment of benefits.

2. Exceptions.

   In certain situations, CareFirst may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount CareFirst will pay for services rendered by non-participating healthcare providers. In these situations, the Member may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. The Member will not be liable for this difference if the non-participating healthcare provider is a non-participating on-call physician who accepts an assignment of benefits.

This amendment is issued to be attached to the Evidence of Coverage. This amendment does not change the terms and conditions of the Evidenceof Coverage, unless specifically stated herein.

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan

An independent licensee of the Blue Cross and Blue Shield Association

Inter-Plan PROGRAM ANCILLARY SERVICES Amendment

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

As used in this amendment, "Out-of-Area Covered Ancillary Services" mean:

1. Independent Clinical Laboratory Tests (performed at non-hospital based labs)
2. Medical Devices and Supplies
3. Specialty Prescription Drugs (non-routine, biological therapeutics such as injectables, infusion therapies, high-cost therapies, and therapies that require complex care)

Under the BlueCard® Program, Members are able to obtain Covered Ancillary Services outside the geographic area that CareFirst services. This program allows Members to obtain Out-of-Area Covered Ancillary Services from providers that have a contractual agreement (i.e., are "participating/PPO providers") with the local Blue Cross and/or Blue Shield Licensee in another geographic area, as well as non-participating providers.

As used in this amendment, the "Local Plan" means the plan that is responsible for processing Out-of-Area Covered Ancillary Services claims under the BlueCard® Program.

Member payment for Out-of-Area Covered Ancillary Services at the participating/PPO or non-participating provider payment level is determined by the relationship between the provider and the Local Plan. If the provider of Covered Ancillary Services has a contract with the Local Plan (a participating/PPO provider), the Member is responsible for the participating/PPO provider member payment as stated in the Inter-Plan Arrangements Disclosure Amendment.

If the provider of Covered Ancillary Services does not have a contract with the Local Plan (a non-participating provider), the Member is responsible for the non-participating provider member payment as stated in the Inter-Plan Arrangements Disclosure Amendment.

For Out-of-Area Covered Ancillary Services, the Local Plan is determined as follows:

Independent Clinical Laboratory Tests - if the referring provider is located in the same service area where the specimen was drawn, the plan of the service area where the specimen was drawn is the Local Plan; if the referring provider is not located in the same service area where the specimen was drawn, the plan of the service area where the referring provider is located is the Local Plan.

Medical Devices and Supplies - the plan of the service area where the equipment was shipped to or purchased at a retail store is the Local Plan.

Specialty Prescription Drugs - the plan of the service area where the ordering physician is located is the Local Plan.

This amendment is subject to all of the terms and conditions of the Evidence of Coverage to which it is attached and does not change any terms or conditions, except as specifically stated herein.

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President and Chief Executive Officer

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2015 AMENDMENT

This amendment is effective. If no date is shown, this amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

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The Evidence of Coverage is amended as follows:

SECTION A - DEFINED TERMS

1. The definition of "Allowed Benefit" in Section 1 of the Evidence of Coverage is deleted and replaced with the following:

   Allowed Benefit means:

   For a Preferred Provider: 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 that the service is rendered, except for facilities that are paid in accordance with Diagnosis Related Groups ("DRG's"). The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.

   For a Non-Preferred Provider that is a health care practitioner:

   A. For a Covered Service rendered by an On-Call Physician or a Hospital-Based Physician who accepts an Assignment of Benefits, the Allowed Benefit is:

      1. For a Hospital-Based Physician, no less than the greater of:

         a) 140% of the average rate CareFirst paid for the 12-month period that ends on January 1 of the previous Calendar Year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to similarly licensed providers, who are Hospital-Based Physicians under written contract with CareFirst; or

b) The final allowed amount of CareFirst for the same Covered Service for the 12-month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the Hospital-Based Physician billing under the same federal tax identification number the Hospital-Based Physician used in Calendar Year 2009.

2. For an On-Call Physician, no less than the greater of:

a) 140% of the average rate CareFirst paid for the 12-month period that ends on January 1 of the previous Calendar Year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to similarly licensed providers under written contract with CareFirst; or

b) The average rate CareFirst paid for the 12-months period that ended on January 1, 2010, in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to a similarly licensed provider not under written contract with CareFirst inflated by the change in the Medicare Economic Index from 2010 to the current year.

The benefit is payable to the On-Call Physician or Hospital-Based Physician who accepts an Assignment of Benefits, except as provided in Section 6.3C, and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.

B. For a Covered Service rendered by an Ambulance Service Provider: The Allowed Benefit for a Covered Service provided by an Ambulance Service Provider that is a Non-Preferred Provider may not be less than the Allowed Benefit paid to a Preferred Ambulance Service Provider for the same Covered Service in the same geographic region, as defined by the Centers for Medicare and Medicaid Services. The benefit is payable to the Ambulance Service Provider in the State of Maryland who accepts an Assignment of Benefits, except as provided in Section 6.3C, and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.

C. For a Covered Service rendered by a United Stated Department of Defense or United States Department of Veterans Affairs health care provider: the Allowed Benefit for a Covered Service rendered by a Non-Preferred Provider that is a United Stated Department of Defense or United States Department of Veterans Affairs health care provider will be no less than the health care provider's actual charge. Benefit payments will be made directly to a United States Department of Defense and the United States Department of Veteran Affairs health care provider.

D. For Emergency Services provided by a Non-Preferred Provider, the Allowed Benefit for a Covered Service will be no less than the amount specified section 2719A of the Public Health Service Act and the regulations promulgated pursuant thereto.

E. For a Covered Service rendered within the Service Area by any other Non-Preferred Provider that is a health care facility, the Allowed Benefit for a Covered Service may be a rate set by a regulatory agency and is no less than the allowed amount paid to a similarly licensed provider who is a Preferred Provider that is a health care facility for the same Covered Service in the same geographic region. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with a health care provider. In that instance, the CareFirst payment will be based on the negotiated fee and the health care provider agrees to accept the amount as payment in full except for any applicable

Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits. The benefit is payable to the Member or to the Non-Preferred Provider at the discretion of CareFirst. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Preferred Provider. In any event, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and, unless the fee is negotiated, for any Balance Bill.

F. For a Covered Service rendered within the Service Area by any other Non-Preferred Provider, including a provider of ambulance services that is not an Ambulance Services Provider: The Allowed Benefit for a Covered Service is no less than the amount paid to a similarly licensed provider who is a Preferred Provider for the same Covered Service in the same geographic region. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with a health care provider. In that instance, the CareFirst payment will be based on the negotiated fee and the health care provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits. For a Non-Preferred Provider who is a physician, the benefit is payable to the physician if the Member has given an Assignment of Benefits, except as provided in Section 6.3C. For any other Non-Preferred Provider who is a health care practitioner, the benefit is payable to the Member or to the Non-Preferred Provider at the discretion of CareFirst. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Preferred Provider. In any event, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and, unless the fee is negotiated, for any Balance Bill.

G. For Covered Services rendered outside the CareFirst Service Area, see the Inter-Plan Arrangements Disclosure Amendment attached to this Evidence of Coverage for information.

2. All references to "Pediatric Vision Allowed Benefit" in the Evidence of Coverage are deleted and replaced with "Vision Allowed Benefit".

The definition of "Pediatric Vision Allowed Benefit" in Section 1 of the Evidence of Coverage is deleted and replaced with the following:

Vision Allowed Benefit means:

A. For a Contracting Vision Provider, the Vision Allowed Benefit for a Covered Vision Service is the lesser of:

1. The Contracting Vision Provider's actual charge; or

2. The benefit amount, according to the Vision Care Designee's Contracting Vision Provider rate schedule for the Covered Vision Service that applies on the date that the service is rendered.

The benefit payment is made directly to a Contracting Vision Provider. When a Member receives a Covered Vision Service from a Contracting Vision Provider, the benefit payment is accepted as payment in full, except for any applicable Copayment or Coinsurance stated in the Schedule of Benefits. The Contracting Vision Provider may collect any applicable Copayment or Coinsurance.

B. For a Non-Contracting Vision Provider, the Vision Allowed Benefit for a Covered Vision Service is the lesser of:

1. The Non-Contracting Vision Provider's actual charge; or

2. The benefit amount stated in the Schedule of Benefits. The benefit amounts

stated in the Schedule of Benefits, as compared to the benefit amounts provided on the Vision Care Designee's Contracting Vision Provider rate schedule, will be no less than the benefit amounts required to comply with § 14-205 of the Insurance Code.

For a Non-Contracting Vision Provider who is a physician, the benefit is payable to the physician if the Member has given an Assignment of Benefits, except as provided in Section 6.3C. For any other Non-Contracting Vision Provider, the benefit is payable to the Member or to the Non-Contracting Vision Provider at the discretion of the Vision Care Designee. It is the Member's responsibility to apply any Vision Care Designee payments received to the claim from the Non-Contracting Vision Provider. In any event, the Member is responsible for any Balance Bill.

3. The definition of "Benefit Period" is deleted and replaced with the following:

Benefit Period means the contract year during which coverage is provided for Covered Services, Covered Dental Services and Covered Vision Services. For purposes of this definition, contract year means the period of time not to exceed twelve (12) months beginning on the Group's Effective Date.

4. The following definitions are added to the Evidence of Coverage:

Step Therapy or Fail-First Protocol means a protocol established by CareFirst that requires a Prescription Drug or sequence of Prescription Drugs to be used by a Member before a Prescription Drug ordered by the Member's provider is covered.

Step Therapy Drug means a Prescription Drug or sequence of Prescription Drugs required to be used under a Step Therapy or Fail-First Protocol.

Supporting Medical Information, with respect to Step Therapy or Fail-First Protocol, means:

A. A paid claim for a Member from CareFirst or another insurer, nonprofit health service plan or health maintenance organization;

B. A Pharmacy record that documents that a prescription has been filled and delivered to the Member or representative of the Member; or,

C. Other information mutually agreed to by CareFirst and the provider prescribing the Step Therapy Drug.

SECTION B - OPEN ENROLLMENT OPPORTUNITES AND SPECIAL ENROLLMENT

1. Section 2.5C.3, of the Evidence of Coverage is deleted and replaced with:

3. The Subscriber must enroll such a Dependent Child within thirty-one (31) days of the child's First Eligibility Date when an additional premium is due for the enrollment of the Dependent Child. Otherwise, the Dependent Child will not be covered beyond thirty-one (31) days and cannot be enrolled until the next Annual Open Enrollment Period. Coverage beyond thirty-one (31) days may cost an additional premium. An additional premium will be due unless there are three (3) or more Dependent Children under the age of twenty-one (21) already enrolled by the Subscriber.

2. Section 2.6B.2, of the Evidence of Coverage is deleted and replaced with:

2. Individuals eligible for special enrollment. An individual is described in paragraph 2.6B.2 if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph 2.6B.2.a), b), c), d), e), or f) of this section.

a) Current employee only. A current employee is described in paragraph 2.6B.2.a) if the current employee acquires a new Dependent through marriage, birth, Adoption, placement for Adoption or placement for foster care. The foster child is not eligible for coverage under this Evidence of Coverage.

b) Spouse of a participant only. Provided the Group provides coverage for Dependents, an individual is described in paragraph 2.6B.2.b) if either:

(1) The individual becomes the Spouse of a participant; or

(2) The individual is a Spouse of a participant and a child becomes a Dependent of the participant through birth, Adoption, placement for Adoption or placement of a child for foster care. The foster child is not eligible for coverage under this Evidence of Coverage.

c) Current employee and Spouse. A current employee and, provided the Group provides coverage for Dependents, an individual who is or becomes a Spouse of such an employee, are described in paragraph 2.6B.2.c) if either:

(1) The employee and the Spouse become married; or

(2) The employee and Spouse are married and a child becomes a Dependent of the employee through birth, Adoption, placement for Adoption or placement for foster care. The foster child is not eligible for coverage under this Evidence of Coverage.

d) Dependent of a participant only. Provided the Group provides coverage for Dependents, an individual is described in paragraph 2.6B.2.d) if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, Adoption, or placement for Adoption.

e) Current employee and a new Dependent. A current employee and, provided the Group provides coverage for Dependents, an individual who is a Dependent of the employee, are described in paragraph 2.6B.2.e) if the individual becomes a Dependent of the employee through marriage, birth, Adoption, or placement for Adoption.

f) Current employee, Spouse, and a new Dependent. A current employee, and provided the Group provides coverage for Dependents, the employee's Spouse and the employee's Dependent are described in paragraph 2.6B.2.f) if the Dependent becomes a Dependent of the employee through marriage, birth, Adoption, or placement for Adoption.

3. Section 2.6C, of the Evidence of Coverage is deleted and replaced with:

C. Applying for special enrollment and effective date of coverage.

1. If a Subscriber enrolls within 31 days of any event described in paragraph 2.6A.3 or paragraph 2.6B.2 of this section, except for when the special enrollment period is the result of a child placed for foster care, the Subscriber and his or her Dependents will be treated as timely enrolled. In the event of a loss of eligibility of coverage due to the operation of a lifetime limit on all benefits, the Subscriber and his or her Dependents will be treated as timely enrolled if the Subscriber enrolls within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.

2. Timely enrollment under paragraph 2.6C.1 will be effective as stated in the Eligibility Schedule.

3. If a Subscriber enrolls within 31 days of a child placed for foster care, the Subscriber and his or her Dependents will be treated as timely enrolled. The foster child is not eligible for coverage under this Evidence of Coverage. The effective date of coverage is the date of placement by the foster care agency.

4. Section 2.6E of the Evidence of Coverage is deleted and replaced with:

E. Other Special Enrollment Period Availability.

1. An eligible employee or Dependent is eligible for special enrollment under this section if an eligible employee or Dependent loses minimum essential coverage.

a) Loss of minimum essential coverage under paragraph 2.6E.1 of this section does not include loss of coverage due to:

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage; or

(2) A rescission under 45 C.F.R. 147.128.

b) The special enrollment period for an eligible employee or Dependent who meets the requirement for a triggering event under paragraph 2.6E.1 of this section shall be for thirty (30) days, beginning on the date of the triggering event.

2. An eligible employee or Dependent is eligible for special enrollment under this section if an eligible employee or Dependent loses pregnancy-related coverage described in 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)). The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or

3. An eligible employee or Dependent is eligible for special enrollment under this section if an eligible employee or Dependent loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per Calendar Year. The date of the loss of coverage is the last day the consumer would have medically needy coverage.

4. It has been determined by the SHOP Exchange that an eligible individual or Dependent,

(a) Was not enrolled in QHP coverage or was not enrolled in the QHP selected by the eligible individual as a result of misconduct on the part of a non-SHOP Exchange entity providing enrollment assistance or conducting enrollment activities; or,

(b) Is eligible for but is not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities.

For purposes of this provision, misconduct includes, but is not limited to, the failure of the non-Exchange entity to comply with applicable standards 45 CFR §155, 45 CFR §156 or other applicable Federal or State laws, as determined by the SHOP Exchange.

5. The eligible individual or Dependent gains access to new health benefit plans as a result of a permanent move.

6. The eligible individual or Dependent, who is an enrollee in a Qualified Health Plan on the SHOP Exchange, demonstrates to the SHOP Exchange that the Qualified Health Plan on the SHOP Exchange in which he or she has enrolled substantially violated a material provision of its contract in relation to the eligible individual or Dependent.

7. Special Enrollment Period. For all qualifying events listed in Section 2.6E, the special enrollment period shall be the thirty (30) day period from the date of the qualifying event.

SECTION C - TERMINATION OF ENROLLMENT BY THE SUBSCRIBER DUE TO QUALIFYING EVENTS

Section 3.2A of the Evidence of Coverage is deleted and replaced with:

3.2. Termination of Enrollment by the Subscriber Due to Qualifying Events.

A. Qualifying Life Events. If certain life events occur and subject to the limitations of Section 3.6, a Subscriber may be able to make a mid-year change to reduce and/or terminate the coverage of the Subscriber or Dependent. The following is a list of qualifying life events that allow the Subscriber to reduce or terminate coverage. The changes in coverage must satisfy the consistency requirements as described below.

1. Legal marital status. A change in a Member's legal marital status, including marriage, divorce, death of spouse, a legal separation or an annulment.

2. Employment status. A change in a Subscriber's, Spouse's or Dependent's employment status due to termination or commencement of employment, a strike or lockout, an unpaid leave of absence, or a change in worksite.

3. Dependent status. A change in status of a Dependent that results in the Dependent's eligibility or ineligibility for coverage because of age or similar circumstances.

4. Any of the qualifying events listed in Section 2.6B, 2.6D or 2.6Eof the Evidence of Coverage, not otherwise specified in this provision.

5. Any reduction or termination that a Subscriber makes must be consistent with the life event. The life event must affect eligibility for coverage under the plan or under a plan of the spouse or Dependent, which covers the spouse or Dependent as a Subscriber. The change in coverage must correspond with the life event.

SECTION D - RETAIL HEALTH CLINICS

The following provision is added to Section 1 of the Description of Covered Services:

1.24 Retail Health Clinics. Coverage is provided for treatment of common conditions or ailments, which require rapid and specific treatment that can be administered in a limited duration of time. Retail Health Clinics are mini-medical office chains typically staffed by nurse practitioners with an on-call physician. Retail Health Clinic services are non-emergency and non-urgent services for common ailments for which a reasonable, prudent layperson who possesses an average knowledge of health and medicine would seek in a Retail Health Clinic, including, but not limited to: ear, bladder, and sinus infections; pink

eye; flu, and strep throat.

SECTION E - PEDIATRIC DENTAL SERVICES

1. In Section 2.4 of the Description of Covered Services, Class III - Major Services - Surgical, Section 2.4A.3, related to occlusal adjustments, is deleted.

2. In Section 2.5 of the Description of Covered Services, Class IV - Major Services - Restorative, Section 2.5G and Section 2.5H, related to occlusal adjustments, are deleted.

3. Section 2.4 of the Description of Covered Services, Class III - Major Services - Surgical is amended to add the following as new item D:

   D. Limited or complete occlusal adjustments.

4. Section 2.4 of the Description of Covered Services, Class III - Major Services - Surgical is amended to renumber current item D as item E.

SECTION F - PRESCRIPTION DRUG COVERAGE

1. Section 11 of the Description of Covered Services is amended to add the following:

   11.3 Step Therapy or Fail-First Protocol. Prescription Drugs subject to Step Therapy or Fail-First Protocols are listed in the Prior Authorization List.

   CareFirst will not impose a Step Therapy or Fail-First Protocol on a Member if:

   A. The Step Therapy Drug has not been approved by the FDA for the f medical condition being treated; or,

   B. The Member's prescribing provider provides Supporting Medical Information to CareFirst that a covered Prescription Drug:

      1. Was ordered for the Member by a prescriber for the Member within the past one hundred eighty (180) days; and,

      2. Based on the professional judgment of the Member's prescribing provider, was effective in treating the Member's disease or medical condition.

2. Section 14.5B.3 of the Description of Covered Services is deleted and replaced with the following:

   3. If a provider prescribes a non-Preferred Brand Name Drug, and the Member selects the non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the non-Preferred Brand Name Drug Copayment or Coinsurance when Medically Necessary, as determined by CareFirst.

SECTION G - COMPLEX CHRONIC OR HIGH RISK ACUTE DISEASE MANAGEMENT

Section 13 of the Description of Covered Services is deleted and replaced with the following:

13.1 Definitions.

Chronic Care Coordination Program (CCC Program) means the assessment and coordination of primary care services to a Qualified Member with multiple chronic and severe health conditions.

Complex Case Management Program (CCM Program) means the assessment and coordination of specialty services provided to a Qualified Member with advanced or critical illnesses.

Designated Provider means a provider contracted with CareFirst to provide services under CareFirst's Total Care and Cost Improvement Program, which includes the following components: PCMH Program, CCM Program, CCC Program, Comprehensive Medication Review, Enhanced Monitoring Program, Expert Consultation Program, Home-Based Services Program, Hospice and Palliative Care Program, Pharmacy Coordination Program, Substance Abuse and Behavioral Health Program, or other community-based programs outlined in this Section (collectively, the "TCCI Programs") and who has agreed to participate in care coordination activities in cooperation with CareFirst for Qualified Members with complex chronic disease or high risk acute conditions.

Primary Care Physician (PCP) means a Preferred Provider, selected by a Member to provide and manage the Member's health care, who is a health care practitioner in the following disciplines:

A. General practice medicine;

B. General internal medicine;

C. Family practice medicine;

D. Pediatric medicine; or

E. Geriatric medicine.

Qualified Member means a Member who:

A. Is accepted by CareFirst into one or more of the TCCI Programs described in this Section. CareFirst will consult with the Member's treating physician or nurse practitioner to determine whether the Member has a medical condition that meets the parameters for participation in one or more of the TCCI Programs.

B. Consents to participate and complies with all elements of the TCCI Program(s) in which he/she qualifies including use of a Designated Provider.

C. Continues to meet the criteria for participation in the TCCI Program(s) and participates fully with any applicable plan of care or other requirements, including compliance with direction from a PCP or Specialist while under a plan of care.

D. CareFirst and the Qualified Member's treating physician or nurse practitioner determine is cooperating with, and satisfying the requirements of the TCCI Program(s). CareFirst retains final authority to determine whether a Member is a Qualified Member.

13.2 Benefits and Cost Sharing Waiver.

A. Qualified Members are eligible for a waiver of their cost sharing responsibility for benefits provided under this Section when:

1. While in an active plan of care, the Qualified Member participates in either (a) a CCC Program coordinated by the Qualified Member's PCP who participates in CareFirst's Patient-Centered Medical Home Program or (b) a CCM Program coordinated by the Qualified Member's Specialist, or

2. At CareFirst's initiation, and in consultation with and direction from the Qualified Member's treating provider or nurse practitioner, the Qualified Member participates in one or more of the TCCI Program elements outside of a plan of care and without participating in CCM Program or CCC Program.

B. Qualified Members participating in a CCM Program or CCC Program as set forth in Section 13.2A.1 are eligible for the following CCM Program and CCC Program benefits while in an active plan of care:

1. Assessment of Qualified Member/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;

2. Education of Qualified Member/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;

3. Assistance in navigating and coordinating health care services and understanding benefits;

4. Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Member's care;

5. Assistance in arranging consultation(s) with Specialists;

6. Identification of and connection to community resources, and other organizations/support services to supplement the Qualified Member's plan of care;

7. Implementation of a plan of care under the direction of the Qualified Member's treating physician or nurse practitioner.

8. Coordination of care, either telephonically or otherwise, between a Designated Provider and a Qualified Member and his/her treating physician.

9. Other Medically Necessary services provided to a Qualified Member while in an active plan of care.

C. Qualified Members participating in a CCM Program or CCC Program while in an active plan of care under Section 13.2A.1 or, pursuant to CareFirst initiation under Section 13.2A.2, are eligible for benefits under following TCCI Program elements:

1. Comprehensive Medication Review (CMR). Benefits will be provided for a pharmacist's review of medications and consultation with the Qualified Member to improve the effectiveness of pharmaceutical therapy.

2. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Member with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Member's chronic condition or disease.

3. Expert Consultation Program (ECP). Benefits will be provided for a review by a team of specialists of a Qualified Member's medical records where the Qualified Member has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

4. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in a home-based care management plan. Covered Services provided to a Qualified Member pursuant to a home-based care

management plan under this section will not count toward any visit limits stated in the Schedule of Benefits.

5. Hospice and Palliative Care Program. Benefits will be provided for medical and associated services specifically outlined in a hospice/palliative plan of care.

6. Pharmacy Coordination Program. Benefits will be provided for care coordination services related to a Qualified Member's use of Specialty Drugs.

7. Substance Abuse and Behavioral Health Program. Benefits will be provided for care coordination services related to a Qualified Member's use of mental health and substance abuse services, including behavioral health treatment benefits.

D. Qualified Member Cost Sharing Responsibilities.

1. Under this section, any applicable cost-sharing responsibilities will be waived for (i) TCCI Program services provided by a Designated Provider and (ii) in-network services provided to Qualified Members in an active plan of care.

   Cost-sharing responsibilities are not waived for any (i) prescription or other drug benefits; (ii) services provided in an inpatient institution or facility; or (iii) services provided in a hospital.

2. If the Qualified Member's Evidence of Coverage is compatible with a federally-qualified Health Savings Account:

   (1) If the Qualified Member has funded his/her HSA account during the Benefit Period, then the Qualified Member will be responsible for any associated costs for services under this Section until the annual Deductible has been met, unless the Covered Services appear on the list of preventive services maintained by the Internal Revenue Service.

   (2) If the Qualified Member has not funded his/her HSA account during the Benefit Period, then if the Qualified Member agrees not to fund his/her HSA account and provides a signed agreement not to fund his/her HSA account, then the Qualified Member will be eligible for the waiver described in 13.2D.1.

E. Termination.

1. The Qualified Member's participation in the TCCI Program(s) and receipt of benefits and cost-sharing waivers under this Section will be terminated under the following circumstances:

   a) The Qualified Member completes the stated goals of the TCCI Program(s) set forth in the Qualified Member's plan of care and confirmed by the Qualified Member's treating physician or nurse practitioner or, if the TCCI Program(s) benefits are provided to Members not in an active plan of care, when confirmed by the Qualified Member's treating physician or nurse practitioner.

   b) The CareFirst designated nurse, provider, or care coordinator and the Qualified Member's treating physician or nurse practitioner determine that the Qualified Member failed to comply with the TCCI Program(s) and/or any related plan of care or treatment under this Section. The Qualified Member will be given thirty (30) days prior written notice of termination under this subsection.

c) The Qualified Member's coverage under this Evidence of Coverage is terminated.

2. If termination is the result of the Qualified Member's failure to comply with the TCCI Program(s) under Section 13.2E.1.(b), the Qualified Member will be provided the opportunity to comply with the TCCI Program(s) during the thirty (30) day notice period. If after consultation between the Qualified Member's treating physician or nurse practitioner and the CareFirst designated nurse, provider, or care coordinator a determination is made that the Qualified Member is not and will not be compliant with the applicable TCCI Program(s), the Qualified Member will receive a final written notice of termination of benefits under this Section.

3. Upon termination of the Qualified Member's participation in the TCCI Program(s), all cost-sharing waivers and benefits shall be null and void on and after the effective date of the termination of the waiver and the Qualified Member will be responsible for any and all cost-sharing responsibilities as stated in the Schedule of Benefits on and after the date of termination of the waiver.]

SECTION H - TRANSITIONING OF CARE FROM MEMBER'S PRIOR CARRIER

Section 14, General Provisions, of the Description of Covered Services, is amended to add the following:

14.7 Transitioning of Care from Member's Prior Carrier.

A. Prior Authorization. For Members transitioning care from the Member's immediate prior carrier to CareFirst:

1. At the request of the Member, the Member's parent, guardian or designee, or the Member's provider, CareFirst will accept a prior authorization from the Member's prior carrier for the procedures, treatments, medications or services which are Covered Services under this Evidence of Coverage; and,

2. For the following time periods:

a) the lesser of the course of treatment or ninety (90) days; and,

b) the duration of the three trimesters of pregnancy and the initial postpartum visit.

3. At the expiration of the time periods stated in A.2 of this provision, CareFirst may elect to perform its own utilization review in order to:

a) reassess and make its own determination regarding the need for continued treatment; and

b) authorize any continued procedure, treatment, medication or other Covered Service determined to be Medically Necessary.

4. With respect to services provided through the Maryland Medical Assistance fee-for-service program, this provision will only apply to:

a) Member's transitioning care from the Maryland Medical Assistance Program to CareFirst; and,

b) Behavioral health and dental benefits, to the extent that that they are authorized by a third-party administrator.

B. Continuing Treatment with a Non-Preferred Provider or Non-Preferred Dentist initiated while covered by the Member's immediate prior carrier:.

1. At the request of the Member, the Member's parent, guardian or designee, or the Member's provider, CareFirst will allow a Member to continue to receive Covered Services rendered by a Non-Preferred Provider or Non-Preferred Dentist at the time of the Member's transition to coverage by CareFirst.

2. Continuing treatment with a Non-Preferred Provider or Non-Preferred Dentist pursuant to this provision is limited to:

   a) acute conditions;

   b) serious chronic conditions;

   c) pregnancy;

   d) mental health conditions and substance use disorders; and,

   e) any other condition on which CareFirst and the Non-Preferred Provider or Non-Preferred Dentist reach an agreement on coverage.

   f) Examples of the conditions set forth in item B.2.a) and b) include:

      (1) bone fractures;

      (2) joint replacements;

      (3) heart attacks;

      (4) cancer;

      (5) HIV/AIDS; and,

      (6) organ transplants.

3. The Member may continue care with the Non-Preferred Provider or Non-Preferred Dentist for the following time periods:

   a) the lesser of the course of treatment or ninety (90) days; and,

   b) the duration of the three trimesters of pregnancy and the initial postpartum visit.

4. For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, CareFirst will treat the services rendered by the Non-Preferred Provider or Non-Preferred Dentist as if the service was provided by a Preferred Provider or Preferred Dentist. The Member is not responsible for the difference between the Allowed Benefit paid to a Preferred Provider or the Pediatric Dental Allowed Benefit paid to a Preferred Dentist and the charge by a Non-Preferred Provider or Non-Preferred Dentist if the Non-Preferred Provider or Non-Preferred Dentist accepts the Allowed Benefit paid to a Preferred Provider or the Pediatric Dental Allowed Benefit paid to a Preferred Dentist as payment in full or the Non-Preferred Provider or Non-Preferred Dentist agrees to an alternative payment amount from CareFirst.

5. If the Non-Preferred Provider does not accept the Allowed Benefit paid to a Preferred Provider or the Non-Preferred Dentist does not accept the Pediatric Dental Allowed Benefit paid to a Preferred Dentist and CareFirst cannot reach an agreement with the Non-Preferred Provider or Non-Preferred Dentist concerning payment for Covered Services:

   a) The Non-Preferred Provider is not required to continue to provide Covered Services and the Non-Preferred Dentist is not required to provide the Covered Dental Services.

   b) If the Non-Preferred Provider accepts the Member's Assignment of Benefits, the Non-Preferred Provider may Balance Bill the Member for the difference between the Allowed Benefit paid to a Preferred Provider and the charge by a Non-Preferred Provider. If the Non-Preferred Dentist accepts the Member's Assignment of Benefits, the Non-Preferred Dentist may Balance Bill the Member for the difference between the Pediatric Dental Allowed Benefit paid to a Preferred Dentist and the charge by a Non-Preferred Dentist.

   c) Unless the Member has executed an Assignment of Benefits to the Non-Preferred Provider or Non-Preferred Dentist, CareFirst will facilitate transfer of care of the Member to a Preferred Provider or Preferred Dentist.

SECTION I - UTILIZATION MANAGEMENT

1. Section 14.1B.2 of the Description of Covered Services is deleted and replaced with the following:

   2. Member Responsibilities.

      a) Members are required to submit claims for Covered Services, Covered Dental Services and Covered Vision Services rendered by Non-Preferred Providers, Non-Participating Dentists Non-Contracting Vision Providers and non-Contracting Pharmacy Providers . Members may have claims submitted by a Non-Preferred Provider, a Non-Participating Dentist a Non- Contracting Vision Provider or a non-Contracting Pharmacy Provider on their behalf. A claim submitted by a Non-Preferred Provider, Non-Participating Dentist, and Non- Contracting Vision Provider on behalf of a Member must be submitted within the time frame granted to the Member to file the claim. Refer to Section 6.2 of the Evidence of Coverage for claims submission requirements and Section 6.3 of the Evidence of Coverage for the Member's ability to make an Assignment of Benefits to certain providers.

      b) Covered Services or Covered Vision Services may require prior authorization. Please see Section 15, Utilization Management Requirements, for a description of the utilization management/prior authorization requirements and the Covered Services and Covered Vision Services that require prior authorization. Section 15.5 states when the Member is responsible to obtain prior authorization for a Covered Service or Covered Vision Service that requires it. As stated in Section 14.3F, the Member is required in all circumstances to obtain and submit to CareFirst the required pre-treatment estimate for orthodontic services obtained from a Preferred Dentist, a Participating Dentist or a Non-Participating Dentist.

2. The introductory paragraph to Section 15, Utilization Management Requirements, of the Description of Covered Services is deleted and replaced with the following:

   Failure to meet the requirements of the Utilization Management Program stated in this Section may result in a reduction or denial of benefits even if the services are Medically Necessary.

3. Section 15.2 of the Description of Covered Services is deleted and replaced with the following:

   15.2 Preferred Provider Responsibility.

   A. Within the CareFirst Service Area, prior authorization will be obtained by Preferred Providers, Contracting Vision Providers and Contracting Pharmacy Providers. These providers are also responsible for providing utilization management notices and obtaining necessary utilization management approvals on the Member's behalf for services that require prior authorization. However, the Member must advise the Preferred Provider that such coverage exists. If the Preferred Provider, Contracting Vision Provider or Contracting Pharmacy Provider fails to obtain prior authorization, the Member shall be held harmless.

   B. Outside of the CareFirst Service Area, a Preferred Provider under the Inter-Plan Arrangements Disclosure Amendment will obtain prior authorization for hospital inpatient services, inpatient mental health and Substance Abuse services, Skilled Nursing Facility Services and inpatient hospice care services only. In all other instances, the Member is responsible for obtaining prior authorization for Covered Services or Covered Vision Services outside of the Service Area. As stated in Section 14.3F, the Member is also required to obtain and submit to CareFirst the required pre-treatment estimate for orthodontic services obtained outside of the Service Area.

4. Section 15.3 of the Description of Covered Services is deleted and replaced with the following:

   15.3 Member Responsibility. Except as provided in Section 15.2B above, the Member is responsible for obtaining all required prior authorizations for Covered Services or Covered Vision Services rendered by Non-Participating Providers or Non-Contracting Vision Providers. As stated in Section 14.3F, the Member is also required to obtain and submit to CareFirst the required pre-treatment estimate for orthodontic services obtained from a Preferred Dentist, a Participating Dentist or a Non-Participating Dentist. It is the Member's responsibility to ensure that providers associated with the Member's care cooperate with utilization management requirements. This includes initial notification in a timely manner, responding to CareFirst inquiries and, if requested, allowing CareFirst representatives to review medical records on-site or in CareFirst offices. If CareFirst is unable to conduct utilization reviews, Member benefits may be reduced or excluded from coverage.

   See Section 15.5 for Covered Services and Covered Vision Services for which the Member must obtain prior authorization. See Section 14.3F for orthodontic services that require a pre-treatment estimate (PTE).

5. The following provision is added to Section 15.5E, Services Subject to Utilization Management, of the Description of Covered Services, as provision 10:

   10. Artificial insemination and intrauterine insemination

This amendment is issued to be attached to the Evidence of Coverage. This amendment does not change the terms and conditions of the Evidence of Coverage, unless specifically stated herein.

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan.

An independent licensee of the Blue Cross and Blue Shield Association.

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
  - $300,000 for disability insurance
  - $300,000 for long-term care insurance
  - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

NOTE: Certain policies and contracts many not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health
Insurance Guaranty Corporation
9199 Reisterstown Road
P.O Box 671-Suite 216C
Owings Mills, Maryland.21117
410-998-3907

Maryland Insurance
Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland.21202
1-800-492-6116, ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

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COMPENSATION AND PREMIUM DISCLOSURE STATEMENT

Our compensation to providers who offer health care services and behavioral health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your physician, please call our Member Services Department at the number listed on your identification card, or write to:

Group Hospitalization and Medical Services, Inc.
doing business as CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
Attention: Member Services

A. METHODS OF PAYING PHYSICIANS

This table shows definitions of how insurance carriers may pay physicians (or other providers) for your health care services with a simple example of how each payment mechanism works.	
Terms	The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.
Salary	A physician (or other provider) is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services. Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing pre-natal care to Mrs. Smith, who is a member of the HMO, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have an effect upon Dr. Jones' salary.
Capitation	A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires. Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr.

	Jones is the same whether or not Mrs. Smith requires obstetric services.
This table shows definitions of how insurance carriers may pay physicians (or other providers) for your health care services with a simple example of how each payment mechanism works.	
Fee-for- Service	A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder. Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.
Discounted Fee-for-Service	Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician (or other provider), who usually gets an increased volume of patients. Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs. Dr. Jones will be paid a discounted rate by the insurer or HMO.
Bonus	A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services. An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.
Case Rate	The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care. This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.

B. PERCENTAGE OF PROVIDER PAYMENT METHODS

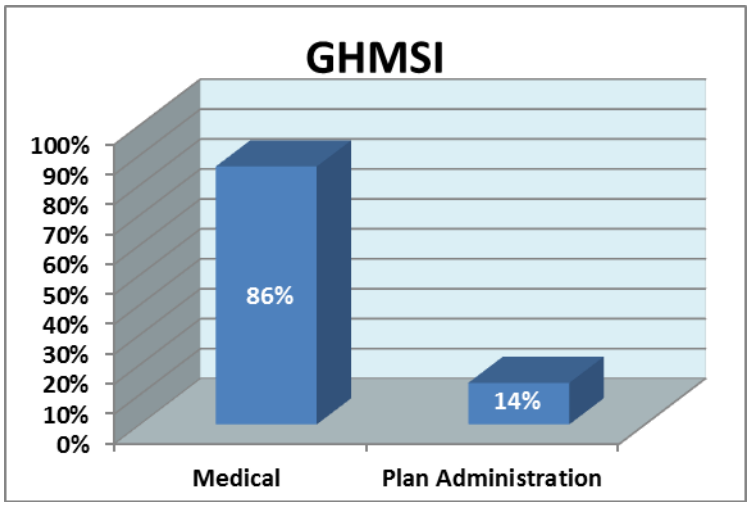
For its Indemnity and Preferred Provider Organization (PPO) products, CareFirst BlueCross BlueShield contracts directly with physicians. All physicians are reimbursed on a discounted fee-for-service basis.

C. DISTRIBUTION OF PREMIUM DOLLARS

The bar graph below illustrates the proportion of every $100 in premium used by CareFirst BlueCross BlueShield to pay providers for medical care expenses, and the proportion used to pay for plan administration.

These numbers represent an average for all indemnity accounts based on our annual statement. The ratio of direct medical care expenses to plan administration will vary by account.

The composite distribution presented in this disclosure is presented pursuant to the requirements of Maryland law, and may differ from calculations of federal medical loss ratio for a carrier in a particular market under the requirements of the Patient Protection and Affordable Care Act, based on accounting differences in the formulae used.



PATIENT PROTECTION DISCLOSURE NOTICE

Primary Care Provider Designation

CareFirst generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, CareFirst designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the CareFirst at the customer service telephone number listed on your identification card.

For children, you may designate a CareFirst pediatrician as the primary care provider.

Obstetrics and Gynecological Care

You do not need prior authorization from CareFirst or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of CareFirst health care professionals who specialize in obstetrics or gynecology, contact CareFirst at customer service telephone number listed on your identification card.

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GROUP INCENTIVE PROGRAM RIDER

This rider is issued by CareFirst to be attached to and become part of the Evidence of Coverage. A Member's effective date of coverage under this rider and termination date of coverage under this rider are the same as the Member's effective date and termination date under the Evidence of Coverage.

This rider adds an incentive program to the Evidence of Coverage that rewards Members for: 1) selecting and visiting specific health care providers to manage the Member's care; 2) completing a Health Assessment that the Member and Member's health care provider may use to initiate healthy behavior; and 3) permitting the receipt of electronic notices and documents. This rider also adds an outcomes-based incentive that rewards Members for achieving or maintaining certain goals related to health status.

Members receive incentives in the form of a credit to a medical expense debit card.

TABLE OF CONTENTS

A. DEFINITIONS:

In addition to the definitions contained in the Evidence of Coverage to which this rider is attached, the underlined terms below, when capitalized, have the following meanings:

Annual Incentive means the amount of the reward provided to Eligible Members for satisfaction of the incentive requirements set forth in Section B of this rider.

PCMH Primary Care Provider (PCMH PCP) means a Primary Care Provider that participates in the CareFirst Patient-Centered Medical Home Program.

Health Assessment means a (1) questionnaire that asks about the Member's age, habits, recent test results and medical history and (2) a health and wellness evaluation that is performed by the Member's PCMH PCP or as provided in Section E.9 and Section E.10, below, including diagnostic screenings to identify potential health risks. Based on the answers and information provided, the Health Assessment will explain risk factors and suggest changes the Member can make to improve and maintain his or her health.

B. INCENTIVE ACTIVITIES AND REQUIREMENTS:

Members who successfully complete each of the following requirements ("Eligible Members") will be provided an Annual Incentive in the form of a medical expense debit card, which can be used to pay any Copayments, Coinsurance, or Deductibles.

1. Select a PCMH PCP.
A Member must select a PCMH PCP within 120 days of enrollment or renewal.

2. Wellness Visit to PCMH PCP.

A Member must visit the selected PCMH PCP for the Member's annual wellness visit and Health Assessment diagnostic screening within 120 days of enrollment or renewal.

3. Complete the Health Assessment Questionnaire.

A Member must complete, consent to release, and share with his or her PCMH PCP the Health Assessment questionnaire within 120 days of enrollment or renewal.

4. Consent to Receipt of Wellness-Related Communications.

A Member must provide consent to receive communications related to healthy lifestyles, well-being, wellness, and disease management information and activities within 120 days of enrollment or renewal. These communications will be provided by electronic means.

C. WELLNESS INCENTIVE BASED ON MEMBER OUTCOMES

These incentives are awarded to Eligible Members who achieve or maintain certain goals related to their health status.

An Eligible Member may be rewarded for achieving or obtaining certain health factors within certain ranges as reported through the Member's health and wellness evaluation. An Eligible Member who demonstrates compliance with the following ranges within 120 days of enrollment or renewal earns a credit to the medical expense debit card:

Health Factor	Target Profile
1. Body Mass Index	From 19 to less than30
2. Blood Pressure	140/90 (until age 59) 150/90 (age 60 and older)
3. Blood Glucose	Less than 100 (fasting)
4. Tobacco	Non User
5. Influenza immunization	Annual

Child Members who are eligible must only comply with Health Factor numbers 1 (Body Mass Index) and 5 (Influenza immunization) to be eligible for an incentive under this section.

The incentive amounts listed in D.2, below are available to all Eligible Members.

Upon request, or if the eligible member does not meet the targets stated in the chart, CareFirst BlueChoice will provide a reasonable alternative standard to, or waiver of, the targets listed in the chart. The Eligible Member's PCMH PCP shall develop the reasonable alternative standard. The Eligible Member shall then be rescreened at a time determined by the Eligible Member's PCMH PCP and the PCMH PCP shall determine whether the Eligible Member has satisfied the reasonable alternative standard.

To request a reasonable alternative standard, the Eligible Member and PCMH PCP shall complete the CareFirst BlueChoice Health and Wellness form noting that an alternative standard was set at the Eligible Member's initial screening. The completed form must then be submitted by the Eligible Member by logging into *My Account* at **www.carefirst.com**.

At the time determined by the Eligible Member's PCMH PCP, the Eligible Member shall be rescreened and a second version of the CareFirst BlueChoice Health and Wellness form shall be completed noting whether the alternative standard was met. The completed form must be submitted by the Eligible Member by logging into *My Account* at **www.carefirst.com**.

If it is not medically advisable for the Eligible Member to be measured on a specific health factor, the PCMH PCP may waive any or all of the health factors listed above.

Eligible Members are able to qualify for the incentive in this Section once per Benefit Period.

D. INCENTIVE AMOUNTS

1. PCMH PCP. Members who select a PCMH PCP and complete the participation requirements in Section B will receive the Annual Incentive in the form of a medical expense debit card equal to the following:

   a) For an adult, a maximum incentive of $200 per Benefit Period.

   b) For a child, a maximum incentive of $50 per Benefit Period.

   Eligible Members will be issued the Annual Incentive on an individual basis as the credit is earned. However, for a family, the Annual Incentive amount received cannot exceed a value of $500 per Benefit Period. If the award of the Annual Incentive to an Eligible Member results in exceeding the maximum credit allowed to a family, the Annual Incentive issued to the Eligible Member will be adjusted accordingly.

2. Wellness Incentives Based on Member Outcomes. Eligible Members who satisfy the requirements stated in Section C will receive the wellness incentive in the form of a medical expense debit card equal to the following:

   a) For an adult, a maximum incentive of $100 per Benefit Period.

   b) For a child, a maximum incentive of $25 per Benefit Period.

   Eligible Members will be issued the wellness incentive on an individual basis as the incentive is earned. However, for a family, the wellness incentive amount received cannot exceed a value of $250 per Benefit Period. If the award of the wellness incentive to an Eligible Member results in exceeding the maximum credit allowed to a family, the wellness incentive issued to the Eligible Member will be adjusted accordingly.

E. CONDITIONS AND LIMITATIONS

1. Members are eligible to qualify for each incentive once per Benefit Period.

2. During the course of each Calendar Year, Providers may join or leave the PCMH program at any time.

3. Only one medical expense debit card credited with any earned incentives will be issued per family. The medical expense debit card may be used by any Member in the family.

4. Once a Member has selected a PCMH PCP, the Member can satisfy the incentive requirements by receiving the required services from any PCP in the PCP's practice, if the Member is unable to obtain an appointment with the selected PCP to satisfy the time frames set forth in Section B.

5. Once the Annual Incentive is awarded in a Benefit Period, it will not be withdrawn nor any amounts recouped during the Benefit Period.

6. The Wellness Incentive Based on Member Outcomes in Section C is only available to Members that first satisfy the Incentive Activities and Requirements in Section B.

7. Members agree to comply with any requirements concerning the use of the medical expense debit card.

8. If the Member's Evidence of Coverage is compatible with a federally-qualified Health Savings Account, the medical expense debit card cannot be used to pay for qualified medical expenses or other cost-sharing responsibilities until the Member first satisfies his/her Deductible.

9. Members residing outside of CareFirst's service area will earn the incentive in Section B by selecting a participating PCP in the Blue Cross and Blue Shield Plan where the Member resides and completing the activities identified in Section B.2 through B.4.

10. Members may satisfy the Health Assessment requirement in Section B.2 by receiving the health and wellness evaluation, including diagnostic screenings or other steps to measure and evaluate the Member's health or risk factors, through any employer-directed process approved by CareFirst so long as the Member consents to share the results, and shares the results, with the Member's PCMH PCP within the designated timeframes to qualify for the wellness incentive.

This rider is issued to be attached to the Evidence of Coverage.

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer

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ATTACHMENT D
ELIGIBILITY SCHEDULE

Effective Date	Effective as of the Group Effective Date
ELIGIBILITY	
Eligible Employee	An eligible employee is: A full-time employee who works on average at least (30) hours per week.
Spouse	Coverage for a Spouse is available.
Dependent Children	Coverage for Dependent Children is available.
Limiting Age for Dependent Children (other than an incapacitated Dependent Child)	Age 26
ENROLLMENT PERIODS AND EFFECTIVE DATES	
Annual Open Enrollment and Newly Eligible Employees	
Annual Open Enrollment	Coverage is effective on the Group Contract Effective Date.
Newly Eligible Employee	The enrollment period for a newly eligible employee and any Dependents is thirty (30) days from the date of employment or eligibility, whichever is later. A newly eligible employee is eligible to enroll him or herself and any eligible Dependents on the date of employment or eligibility, whichever is later. The Effective Date of coverage is the date of employment or eligibility, whichever is later.

Special Enrollment Periods	
Newly Eligible Dependent Child: (Newborn Dependent Child, Newly Adopted Dependent Child, a Minor Dependent Child for whom guardianship has been granted by court or testamentary appointment, or MCSO/QMSO)	The Effective Date of coverage for a newly-eligible Dependent Child is the Dependent Child's First Eligibility Date: A. Newly born Dependent Child: the date of birth. B. Adopted Dependent Child: the date of Adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent. C. A Dependent Child who is an eligible grandchild or stepchild (non-newborn), the date the grandchild or stepchild became a dependent of the Subscriber or the Subscriber's Spouse. D. Testamentary or court appointed guardianship of a Dependent Child: the date of appointment. The Special Enrollment Period, except in the case of a Dependent Child who is the subject of a Medical Child Support Order or Qualified Medical Support Order, is the thirty-one (31) day period from the date of the Dependent Child's First Eligibility Date. The Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the First Eligibility Date. Coverage for a newly eligible Dependent Child shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The Subscriber must enroll such a Dependent Child within thirty-one (31) days of the child's First Eligibility Date when an additional premium is due for the enrollment of the Dependent Child. Otherwise, the Dependent Child will not be covered and cannot be enrolled until the next Annual Open Enrollment Period. Coverage beyond thirty-one (31) days may cost an additional premium. An additional premium will be due unless there are three (3) or more Dependent Children under the age of twenty-one (21) already enrolled by the Subscriber. Except as provided below, the Effective Date for Dependent Child who is the subject of a Medical Child Support Order or Qualified Medical Support Order that creates or recognizes the right of the Dependent Child to receive benefits under a parent's health insurance coverage is: A. Medical Child Support Order: the date specified in the Medical Child Support Order. B. Qualified Medical Support Order: the date specified in the Qualified Medical Support Order. However, if the Subscriber has not completed any applicable Waiting Periods for coverage, the child subject to the MCSO/QMSO will not be enrolled, and coverage will not be effective, until the end of the Waiting Period.
Newly Eligible Dependent (including a Spouse or a newly eligible Dependent Child not described above)	The Effective Date of coverage is the first of the month following acceptance of the Enrollment Form by CareFirst.

Subscribers who are eligible for special enrollment (except for those who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility)	Coverage for a Subscriber eligible for special enrollment and any Dependents who enroll at the same time is effective on the first of the month following the date CareFirst receives Enrollment Form.
Dependents who are eligible for special enrollment (except for those who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility)	Coverage for a Dependent who loses coverage and is eligible for special enrollment is effective on the first of the month following the date CareFirst receives Enrollment Form.
Subscribers and Dependents who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility	Coverage for a new Subscriber and/or his/her Dependents is effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or, the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.
TERMINATION OF ENROLLMENT	
Subscriber no longer eligible	Enrollment terminates for the Subscriber and any Dependents on the last day of the month in which the Subscriber's employment or eligibility terminates.
Dependent Child Limiting Age	Enrollment terminates on the last day of the month of the Dependent Child's 26th birthday.
Dependent no longer eligible (on grounds other than Limiting Age)	Enrollment terminates on the last day of the month in which the Member no longer meets the eligibility requirements stated in the Evidence of Coverage.
Death of Subscriber	Coverage for the Subscriber ends on the date of death. Absent any continuation of coverage under Section 4 of the Evidence of Coverage, coverage for any enrolled Dependents ends on the last day of the month after the Subscriber's death.