CareFirst
Family of health care plans

BluePreferred

Your Member Contract

840 First Street, NE
Washington, DC 20065

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®′ Registered trademark of CareFirst of Maryland, Inc.

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Group Hospitalization and Medical Services, Inc.

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

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

This Evidence of Coverage, including any attachments, amendments and riders, is a part of the Group Contract issued to the Group through which the Subscriber is enrolled for health benefits. In addition, the Group Contract includes other provisions that explain the duties of CareFirst and the Group. The Group's payment and CareFirst's issuance 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.

NOTE: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition CareFirst may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Group Name: SMITHSONIAN INSTITUTION

Group Number: 66951

Effective Date: January 1, 2017

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.

Allowed Benefit means:

> **For a Preferred Provider**, the Allowed Benefit for a Covered Service is the amount agreed upon between CareFirst and the Preferred Provider which, in some cases, will be a rate set by a regulatory agency. The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment, and Coinsurance amounts, for which the Member is responsible.
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> **For a Non-Preferred Practitioner**, the Allowed Benefit for a Covered Service is determined in the same manner as the Allowed Benefit for a Preferred Provider. The benefit is payable to the Member or to the provider, at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts and for the difference between the Allowed Benefit and the Practitioner's actual charge. It is the Member's responsibility to apply any CareFirst payments to the Health Care Provider's charges.
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> **For a Non-Preferred Facility**, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or the established fee schedule if one has been established for that type of Eligible Provider and service, except for facilities that are paid in accordance with Diagnosis Related Groups ("DRG's"). If a fee schedule for the type of Eligible Provider and service has not been established, the Allowed Benefit will be based on facility reimbursement methodology. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an Eligible Provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment, and Coinsurance amounts, for which the Member is responsible. The benefit is payable to the Member or to the facility, at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts and, unless negotiated, for the difference between the Allowed Benefit and the Practitioners' actual charge. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Facility.

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 radiology, operating room services, incremental nursing services, blood administrative 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.

Benefit Period means the period of time during which Covered Services including are eligible for payment. The Benefit Period is a Calendar 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.

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.

Contract Renewal Date means the date, specified in the Eligibility Schedule, on which this Evidence of Coverage renews and each anniversary of such date.

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 bench, items available without a prescription).

Conversion Contract means a non-Group health benefits contract issued in accordance with state law to individuals whose coverage through the Group Contract has terminated.

Copayment (Copay) means a fixed dollar amount that a Member must pay for certain Covered Services. When a Member receives multiple services on the same day by the same Health Care Provider, the Member will only be responsible for one (1) Copay.

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

Covered Service means a Medically Necessary service or supply provided in accordance with the terms of this Evidence of Coverage.

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 Covered Services based on the Allowed Benefit, which must be Incurred before CareFirst will pay for all or part of remaining Covered Services. The Deductible is met when the Member receives Covered Services that are subject to the Deductible and pays for these him or herself.

Dependent means a Member who is covered under the Evidence of Coverage as the eligible Spouse or eligible Dependent child.

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

Eligible Provider means either a Health Care Facility or a Health Care Practitioner, as these terms are defined herein, licensed or otherwise authorized by law to provide health care services.

Emergency Services means those health care services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

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,

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.

Evidence of Coverage means this agreement, which includes any attachments, amendments and riders, if any, between the Group and CareFirst. (Also referred to as the Group Contract.)

Experimental/Investigational means a service or supply that is in the developmental stage and in the process of human or animal testing excluding clinical trial Patient Cost coverage as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

A. The Technology* must have final approval from the appropriate government regulatory bodies;

B. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;

C. The Technology must improve the net health outcome;

D. The Technology must be as beneficial as any established alternatives; and,

E. The improvement must be attainable outside the Investigational settings.

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

Exempt Provider means any Health Care Facility or Health Care Practitioner, which, as a class, is not represented in the providers who have agreed to participate as Preferred Providers. A listing of Exempt Provider classes is available from CareFirst upon request.

FDA means the federal Food and Drug Administration.

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

Group Contract means the agreement issued by CareFirst to the Group through which the benefits described in this Evidence of Coverage are made available. In addition to this Evidence of Coverage, the Group Contract includes the Group Contract Application, any attachments, amendments and riders attached to the Group Contract or Evidence of Coverage and signed by an officer of CareFirst.

Habilitative Services means services, including Occupational Therapy, Physical Therapy, and Speech Therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

Health Care Facility means a hospital, ambulatory surgical facility or center, inpatient rehabilitation facility, home health agency, Skilled Nursing Facility, hospice facility, hospice program or partial hospitalization program that is licensed or certified, or both, to operate within the jurisdiction in which it is located.

Health Care Practitioner means a physician, dentist (D.D.S. or D.M.D.) or other provider of health care whose services, by law, must be covered subject to the terms of this Agreement, such as: a chiropodist, chiropractor, doctor of podiatry, doctor of surgical chiropody, nurse anesthetist, nurse midwife, nurse practitioner, optician, optometrist, physical therapist, physiotherapist, audiologist, psychologist, social worker, licensed clinical professional counselor, licensed clinical marriage and family therapist, and licensed clinical alcohol and drug counselor.

Health Care Provider means a Health Care Practitioner licensed or otherwise authorized by law to provide Covered Services.

Incurred means a Member's receipt of a health care service or supply for which a charge is made.

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

Lifetime Maximum means the maximum dollar amount payable toward a Member's claims for Covered Services while the Member is insured under this Group Contract. See the Description of Covered Services and the Schedule of Benefits for specific information as to how the Lifetime Maximum, if any, applies to the benefits under the Group Contract.

Limiting Age means the maximum age up to which an eligible child may be covered under this Evidence of Coverage as stated in the Eligibility Schedule.

Medical Child Support Order means an "order" issued in the format prescribed by federal 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 patient 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 patient's illness, injury or disease;

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

D. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury, or disease.

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

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

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

Non-Preferred Provider means any Health Care Provider that does not contract with CareFirst.

Occupational Therapy means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury, or disability, and that develop, improve, sustain, or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition.

Open Enrollment means a single period of time in each benefit year during which the Group gives eligible individuals the opportunity to change coverage or enroll in coverage.

Out-of-Pocket Limit means the maximum amount the Member will have to pay for his or her share of benefits in any Benefit Period.

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 products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.

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

Plan 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 Provider means a Health Care Provider who is part of a network of Preferred Providers who contract with CareFirst to render Covered Services.

A listing of Preferred Providers will be provided to the Member at the time of enrollment and is also available from CareFirst upon request. The listing of Preferred Providers is subject to change. Members may confirm the status of any Health Care Provider prior to making arrangements to receive care by contacting CareFirst for up-to-date information.

Prescription Drug means a drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;" and, 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.

Private Duty Nursing means Skilled Nursing Care services, ordered by a physician, which can only be provided by a licensed health care professional, based on a Plan of Treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services. If the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same, then Skilled Nursing Care is not Medically Necessary. Skilled Nursing Care excludes services for performing the Activities of Daily Living (ADL), including but not limited to bathing, feeding, and toileting.

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

Rehabilitative Services include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness. The goal of Rehabilitative Services is to return the individual to his or her prior skill and functional level.

Skilled Nursing Care means non-Custodial Care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled

Nursing Care, or Rehabilitative Services.

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

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

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

Spouse means a person of the same or opposite sex who is legally married to the Subscriber under the laws of the state or jurisdiction in which the marriage took place. A marriage legally entered into in another jurisdiction will be recognized as a marriage in the District of Columbia.

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

Type of Coverage means either Individual, which covers the Subscriber only, or Family, under which an Individual may also enroll his or her Dependents. In addition, some Group Contracts list other categories of coverage, including, but not limited to, Individual and Adult, Individual and Child, or Individual and Children. The Type(s) of Coverage available is described in the Eligibility Schedule.

Waiting Period means the period of time that must pass before an employee or Dependent is eligible to enroll under the terms of the Evidence of Coverage.

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage. To be covered, a Member must meet all of the following conditions:

A. The Member must be eligible for coverage either as a Subscriber under Section 2.2, below, as a Spouse under Section 2.3, below, or as a Dependent Child under Sections 2.4 and 2.5 below;

B. The Member must apply for coverage by submitting an Enrollment Application to CareFirst during certain periods set aside for this purpose as described in Section 2.6 below,

C. The Group must notify CareFirst of the Member's enrollment; and

D. CareFirst must receive premium payments on the Member's behalf as required by the Group Contract.

Note: No individual is eligible under the Group coverage both as a Subscriber and as a Dependent. If the Group employs both a husband and wife (or Domestic Partner, if applicable), they may not both have Individual and Adult Coverage or Family Coverage.

2.2 Eligibility as a Subscriber. To enroll as a Subscriber, a Member must meet CareFirst's basic eligibility requirements and any additional eligibility requirements that CareFirst and the Group have agreed to. These are stated in the Eligibility Schedule.

A. Basic Plan Requirements. A Subscriber must be an employee of the Group. Unless otherwise provided by the Group, if a person is a director, trustee, corporate officer, outside counsel, consultant, owner or partner, a person is not eligible, unless he or she is actually employed by the Group and meet the same criteria for coverage that apply to other Group employees. A person is not eligible if he or she is a temporary or seasonal employee. A Subscriber must be employed by the Group on a regular, year-round basis to qualify for coverage.

B. Additional Eligibility Requirements. In addition to the basic eligibility requirements in Section 2.2.A., above, a Member must meet the additional eligibility requirements that are listed in the Group Contract Application. The Group is required to administer these requirements in strict accordance with the terms that have been agreed to and cannot change the requirements or make an exception unless CareFirst approves them in advance, in writing.

2.3 Eligibility of Subscriber's Spouse. A Subscriber may cover his or her legal Spouse as a Dependent. A Subscriber cannot cover a Spouse if the Subscriber and Spouse have divorced or if the marriage has been annulled.

2.4 Eligibility of Dependent Children. If the Group has elected to include coverage for Dependent children of the Subscriber or a Subscriber's Spouse under this Evidence of Coverage, then a Subscriber may enroll a Dependent child. To be covered as a Dependent child, the child:

A. Must meet the age requirements described in Section 2.5, below;

B. If older than the age requirements described in Section 2.5 below, the child may be eligible for coverage if the Subscriber provides proof that: (1) the Dependent child is incapable of self-support or maintenance because of a medical or mental disability; (2) the Dependent child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse for support and maintenance; and (3) 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 medical or mental disability.

C. Must be unmarried; and

D. Must be related to the Subscriber in one of the following ways:

1. The Subscriber's or the Subscriber's Spouse's, Dependent child by birth or legal Adoption;

2. A child placed with the Subscriber or the Subscriber's covered Spouse, for Adoption;

3. Under testamentary or court appointed guardianship, other than temporary guardianship of less than twelve (12) months duration, and who resides with, and is the dependent of, the Subscriber or Subscriber's Spouse;

4. A stepchild who permanently resides in the Subscriber's household and who is dependent upon the Subscriber or the Subscriber's Spouse, for more than half of his or her support;

5. A grandchild, niece or nephew, who meets the requirements for coverage as the Subscriber's Primary Care Dependent as stated below:

a. The child must be the Subscriber's grandchild, niece, or nephew;

b. The child is under the Subscriber's Primary Care. Primary Care, means that the Subscriber provides food, clothing and shelter for the child on a regular and continuous basis during the time that the District of Columbia public schools are in regular session; and,

c. If the child's legal guardian is someone other than the Subscriber, the child's legal guardian is not covered under any other health insurance policy.

The Subscriber must provide us with proof upon application, that the child meets the requirements for coverage as a Primary Care Dependent, including proof of the child's relationship and primary dependency on the Subscriber and certification that the child's legal guardian does not have other coverage. CareFirst reserves the right to verify whether the child is and continues to qualify as a Primary Care Dependent.

E. Is a child who is the subject of a Medical Child Support Order ("MCSO") or a 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.

1. Upon receipt of an MCSO/QMSO, when coverage of the Subscriber's family members is available under the Evidence of Coverage, then CareFirst will accept enrollment of the child subject to an MCSO/QMSO submitted by the Subscriber regardless of enrollment period restrictions. If the Subscriber does not attempt to enroll the child subject to an MCSO/QMSO 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. If the Subscriber has not completed an applicable Waiting Periods for coverage, the child subject to an MCSO/QMSO will not be enrolled 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. The Effective Date will be that stated in the Eligibility Schedule for a newly eligible Subscriber and a newly eligible Dependent child.

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.

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

3. When a child subject to an MCSO/QMSO does not reside with the Subscriber, CareFirst will:

   a. Send the non-insuring, custodial parent ID cards, claim forms, the applicable Evidence of Coverage or Member contract and any information necessary to obtain benefits;

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

   c. Provide benefits directly to the non-insuring custodial parent, the provider of the Covered Services, or the appropriate child support enforcement agency of any State or the District of Columbia.

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

2.5 Limiting Age for Covered Dependent Children.

A. All Dependent children are eligible for coverage up to the Limiting Age for Dependent children, as stated in the Eligibility Schedule.

B. Dependent children may be eligible beyond the Limiting Age for Dependent children if the Eligibility Schedule provides a Limiting Age for Student Dependents and if the Dependent children meet the requirements for Student Dependents, as described below. Coverage, if available, will be provided up to the Limiting Age for Student Dependents as stated in the Eligibility Schedule.

1. Student Dependent means a Dependent child whose attendance at a public or private high school, college, university, graduate school, trade school or other school at which the Dependent child is enrolled meets the institution's requirements for full-time status.

2. CareFirst will provide coverage for an eligible Dependent child who is originally enrolled as a full-time student and becomes unable due to a medical or mental disability to continue as a full-time student. Coverage will continue for a period of twelve (12) months from the date the Dependent child ceases to be a full-time

student or until the Dependent child attains the Limiting Age for Student Dependents as stated in the Eligibility Schedule, whichever occurs first. CareFirst may require verification of the disability from the Dependent child's treating Health Care Provider, a disability services professional employed by the institution that the Dependent child attends, or a Health Care Provider with special expertise in and knowledge of the disability. A Dependent child's status as a full-time student shall be determined in accordance with the criteria specified by the institution in which the Dependent child is enrolled.

3. The Member must provide CareFirst with proof of the Dependent child's student status within 31 days after the Dependent child's coverage would otherwise terminate or within 31 days after the Effective Date of the Dependent child's coverage, whichever is later. CareFirst has the right to verify eligibility status.

C. 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 a medical or mental disability;

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

3. The disability occurred before the covered Dependent child reached the Limiting Age or, if the child was covered beyond the Limiting Age as a Student Dependent, the disability occurred before the covered Dependent child reached the Student Dependent Limiting Age, specified in the Eligibility Schedule; and

4. The Subscriber provides CareFirst with proof of the Dependent child's medical or mental disability within 31 days after the Dependent child reaches the Limiting Age for Dependent children or, if applicable, the Limiting Age for Student Dependents. CareFirst has the right to verify whether the child is and continues to qualify as a disabled Dependent child.

D. 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. Coverage of an ineligible Dependent will terminate as stated in the Eligibility Schedule.

2.6 Timely Enrollment

A Member may enroll as a Subscriber or Dependent, as applicable, during the periods of time and under the conditions described below. If the Member meets these conditions, his or her enrollment will be treated as a Timely Enrollment. Enrollment at other times will be treated as Special Enrollment, as described in Section 2.7, below, or as Late Enrollment, as described in Section 2.8, below, and will be subject to the conditions and limitations of these sections.

A. Initial Enrollment. When the Group first offers CareFirst's coverage, there will be an initial enrollment period for eligible employees. During the initial enrollment period, a Subscriber may apply for coverage for himself or herself and his or her eligible Dependents.

B. Newly Eligible Subscriber. If a Subscriber is a new employee or a newly eligible employee of the Group, new employee or a newly eligible employee may enroll as a Subscriber within sixty (60) days after new employee or a newly eligible employee first becomes eligible. The eligibility requirements for Newly Eligible Subscribers in the Group are stated in the Eligibility Schedule.

C. Coverage of a Newborn Dependent Child, Newly Adopted Dependent Child or a Minor Dependent Child, for whom Guardianship is granted by Court or Testamentary

Appointment, stepchild or Primary Care Dependent. Enrollment requirements for an eligible Newborn Dependent child, Newly Adopted Dependent child, a Minor Dependent child for whom guardianship is granted by court or testamentary appointment, stepchild or Primary Care Dependent depend on the Type of Coverage that is in effect on the date of the child's First Eligibility Date, as defined below.

D. "First Eligibility Date" means:

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

2. For a newly adopted Dependent Child, the earlier of:

   a. A judicial decree of adoption; or

   b. Placement of the Dependent Child in the Subscriber's home as the legally recognized proposed adoptive parent.

3. For a Dependent Child for whom a Member has been granted legal custody, the date of the court decree or the date the court decree becomes effective, whichever is later.

4. For an eligible Primary Care Dependent or stepchild (non-newborn), the date the Primary Care Dependent or stepchild became a Dependent of the Subscriber or Dependent Spouse.

E. Family Coverage. If a Subscriber already has Family Coverage on the Dependent child's First Eligibility Date, a newborn Dependent Child, newly adopted Dependent child, newly eligible Dependent Child stepchild or Primary Care Dependent, or a minor Dependent Child for whom guardianship is granted by court or testamentary appointment will be covered automatically as of the child's First Eligibility Date. Any Type of Coverage listed in the Eligibility Schedule that is not Individual, Individual and Adult or Individual and Child is considered Family coverage.

F. Individual Coverage. If a Subscriber has Individual Coverage on 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 Dependent Child's First Eligibility Date. If a Subscriber wishes to continue coverage beyond this 31 day period, the Subscriber must enroll the child within thirty-one (31) days following the Dependent Child's First Eligibility Date. Premium changes resulting from the addition of the Dependent Child will be effective as of the child's First Eligibility Date

G. Individual and Adult or Individual and Child Coverage. This provision applies only to Groups that offer an Individual and Adult or Individual and Child category of coverage. If a Subscriber has Individual and Adult or Individual and Child coverage on the Dependent Child's First Eligibility Date, the Dependent Child will be covered automatically as of the Dependent Child's First Eligibility Date. However, if addition of the Dependent Child results in a change in the Subscriber's Type of Coverage (e.g., from Individual and Adult or Individual and Child coverage to Family coverage), the Dependent Child's automatic coverage will end on the thirty-first (31st) day following the child's First Eligibility Date. If the Subscriber wishes to continue coverage beyond this thirty-one (31) day period, he or she must enroll the Dependent Child within thirty-one (31) days following the First Eligibility Date. The change in Type of Coverage and corresponding premium for the Subscriber's new Type of Coverage will be made effective as of the child's First Eligibility Date.

H. Coverage of Children under Court or Administrative Order If the Subscriber (or another employee who is otherwise eligible for coverage under this Group Contract) is required under a court or administrative order to provide coverage under this Group Contract for his

or her child, the Subscriber (or employee) may enroll the eligible minor child included in the order and, if required, himself or herself at any time following the date on which the order was signed by a competent court or administrative agency without being subject to any enrollment period restrictions. If the Group is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Group will determine whether an order received by the Group with respect to employees of the Group and their children is a Qualified Medical Support Order or a Medical Child Support Order (as defined under ERISA) and whether such children are eligible for coverage under that order.

I. New Family Member (Other than a newborn, newly adopted child, a minor for whom guardianship is granted by court or testamentary appointment, stepchild or Primary Care Dependent) A Subscriber may enroll new family members, such as a new Spouse or stepchild, and/or change the Subscriber's Type of Coverage to include the new family member within thirty-one (31) days following the date the new family member first becomes eligible.

2.7 Special Enrollment Periods. Special enrollment is allowed for certain 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, special enrollment period for a Spouse /Dependent child are not applicable.

A. Special enrollment for certain individuals who lose coverage:

1. CareFirst will permit current employees and Dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.

2. Individuals eligible for special enrollment.

a. When employee loses coverage. A current employee and any Dependents (including the employee's Spouse) each is 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:

i. The employee and the Dependents are otherwise eligible to enroll;

ii. When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

iii. The employee satisfies the conditions of paragraph A.2.c. i., ii., or iii. of this section, and if applicable, paragraph A.2.c. iv. of this section.

b. When Dependent loses coverage.

i. 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:

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

2) When coverage was previously offered, the Dependent

had coverage under any group health plan or health insurance coverage; and

3) The Dependent satisfies the conditions of paragraph A.2.c. i., ii., or iii., of this section, and if applicable, paragraph A.2.c.iv. of this section.

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

c. Conditions for special enrollment.

i. 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 this paragraph 1.c.i 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 this paragraph 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 this paragraph 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;

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.

ii. Termination of employer contributions. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph 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.

iii. Exhaustion of COBRA continuation coverage. In the case of an employee or Dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph 1.c.i. of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.

iv. 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 this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph 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 to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)

d. Enrollment will be effective as stated in the Eligibility Schedule.

B. Special enrollment with respect to certain Dependent beneficiaries:

1. Provided the Group provides coverage for Dependents, CareFirst will permit the individuals described in paragraph 2.b. 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.

2. Individuals eligible for special enrollment. An individual is described in this paragraph 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 A.2.b or A.2.c.of this section.

a. Current employee only. A current employee is described in this paragraph if a person becomes a Dependent of the individual through marriage, birth, Adoption, or placement for Adoption.

b. Spouse of a participant only. An individual is described in this paragraph if either:

i. The individual becomes the Spouse of a participant; or

ii. 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 an individual who is or becomes a Spouse of such an employee, are described in this paragraph if either:

i. The employee and the Spouse become married; or

ii. 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. An individual is described in this paragraph 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 an individual who is a Dependent of the employee, are described in this paragraph 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, the employee's Spouse, and the employee's Dependent are described in this paragraph if the Dependent becomes a Dependent of the employee through marriage, birth, Adoption, or placement for Adoption.

3 Enrollment will be effective as stated in the Eligibility Schedule.

C. If a Subscriber enrolls within 31 days of any event described in this Section 2.7, the Subscriber and his or her Dependents will be treated as timely enrolled.

D. 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 Dependent child to this Evidence of Coverage outside the 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 Open Enrollment period or 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.

The benefits applicable:

1. for a newborn child (or newborn grandchild or stepchild) shall be payable from the moment of birth and shall continue for 31 days after the date of birth.

2. for an eligible Primary Care Dependent or stepchild (non-newborn) shall be payable from the date the Primary Care Dependent or stepchild became a Dependent of the Subscriber or Dependent Spouse and shall continue for 31 days after that date.

3. for a newly adopted child shall be payable from the date of the Adoption of the child and shall continue for 31 days after the date of the Adoption of the child.

4. for a minor for whom guardianship of at least 12 months duration is granted by court or testamentary appointment shall be payable from the date of appointment and shall continue for 31 days after the date of court or testamentary appointment.

Coverage beyond 31 days may cost an additional premium. This occurs when the addition of the Dependent child changes the Subscriber's Type of Coverage. When additional premium is due, the Subscriber must notify the Group within 31 days of the Effective Date and the additional premium must be paid. Coverage will not be provided beyond the 31 days of automatic coverage when written notification enrolling the eligible Dependent child is not received within the 31-day period and the additional premium is not paid.

When the addition of a Dependent child does not change the Subscriber's Type of Coverage, the Subscriber is requested to provide CareFirst with written notice enrolling the eligible Dependent child.

Coverage for a newborn child or newly adopted child or grandchild, stepchild, or a minor for whom guardianship is granted by court or testamentary appointment shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

E. Special enrollment regarding Medicaid and CHIP termination or eligibility:

1. CareFirst will permit an individual or dependent who is eligible for coverage, but not enrolled, to enroll for coverage under the terms of this Evidence of Coverage, if either of the following conditions is met:

   a. The individual 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 individual or dependent under such a plan is terminated as a result of loss of eligibility for such coverage;

   b. The individual 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 individual must notify the Group, and the Group must notify CareFirst no later than 60 days after the date the individual 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 individual must notify the Group, and the Group must notify CareFirst, no later than 60 days after the date the individual or dependent is determined to be 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).

3. Effective Date of Coverage. If the individual or Dependent is eligible to enroll for coverage under this Evidence of Coverage pursuant to this special enrollment and the notification requirement has been met then such coverage will be effective on:

   a. the date the individual's or Dependent's coverage 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; or,

   b. the date the individual or Dependent is determined to be eligible for premium assistance with respect to coverage under this Evidence of Coverage.

2.8 Late Enrollment. If a Subscriber does not meet the conditions described in Section 2.6 or 2.7, above, or if the Subscriber did not enroll himself or herself and/or the Subscriber's eligible Dependents within the time periods described in Section 2.6 and 2.7, above, the Subscriber may apply for coverage at any time as a Late Enrollee. However, as a Late Enrollee, there may be a delay in the Effective Date of the Subscriber's coverage or the Subscriber may be subject to a Preexisting Condition Exclusion Period. The Eligibility Schedule lists the requirements and conditions that apply to a Late Enrollee.

2.9 Preexisting Condition Exclusion Period. Upon initial enrollment, the Subscriber's coverage may be subject to a Preexisting Condition Exclusion Period. If this period applies to the Subscriber, CareFirst will not provide benefits for any services in connection with a Preexisting Condition for a specified time following the Enrollment Date. Consult the Eligibility Schedule to determine if this Evidence of Coverage includes a Preexisting Condition Exclusion Period, and if so, the circumstances under which a Preexisting Condition Exclusion Period will apply. If the Enrollment Application contains questions about health history or medical treatment history, CareFirst may apply the Preexisting Condition Exclusion Period (in the circumstances described below) to any Preexisting Condition admitted in the Enrollment Application.

If a Subscriber is required to provide this information, CareFirst will notify the Subscriber upon enrollment of the specific Preexisting Condition for which no benefits will be provided during the Preexisting Condition Exclusion Period, based on the information provided to CareFirst. CareFirst is required to issue a signed waiver in order to apply the Preexisting Condition Exclusion Period to any Preexisting Condition disclosed in the Enrollment Application. If a signed waiver is not attached, any condition disclosed in the Enrollment Application will not be considered a Preexisting Condition and will be covered without a Preexisting Condition Exclusion Period. However, if the Enrollment Application does not ask for a health history and medical treatment history, or if the Subscriber is asked to provide this information but the information provided to CareFirst contains a material misrepresentation of fact, CareFirst is not required to issue a waiver. In these instances, CareFirst can deny benefits for a Preexisting Condition during the Subscriber's Preexisting Condition Exclusion Period, based on CareFirst's findings as claims are received.

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

2.11 Clerical or Administrative Error. If a Member is ineligible for coverage, the Member 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 his or her coverage because CareFirst or the Group made an administrative or clerical error in recording or reporting information.

2.12 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.

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 charges when due, including premium contributions that may be required by the Group. Coverage ends on the date stated in CareFirst's written notice of termination (after the expiration of any grace period for nonpayment of premiums).

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

3. The Member provided false or misleading information on the application for the purpose of defrauding CareFirst or any other person. Additionally CareFirst may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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 changes the Type of Coverage to an Individual or other non-family contract.

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, the marriage of a Dependent child, or termination of a Student Dependent's status as a full-time student. 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.

H. Subject to the Contestability of Coverage provision in the Group Contract, CareFirst can terminate a Member's coverage with thirty-one (31) days prior written notice if CareFirst determines that the Member:

1. Made an intentional misrepresentation of information that is material to the acceptance of the Enrollment Application. As a Member, the Member represents

that all information contained in the Member's Enrollment Application is true, correct and complete to the best of his or her knowledge and belief.

2. Fraudulent use of CareFirst membership card on the part of the Member, the alteration or sale of prescriptions by the Member, or an attempt by the Subscriber to enroll non-eligible persons as Dependents. The card must be returned to CareFirst upon request. Coverage ends on the date stated in CareFirst's written notice of termination.

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

3.2 Death of a Subscriber. In the event of the Subscriber's death, coverage of any Dependents will continue under the Subscriber's enrollment as stated in the Eligibility Schedule.

3.3 Medical Child Support Orders or Qualified Medical Support Orders
Unless coverage is terminated for non-payment of the Premium, a Dependent child subject to an MCSO/QMSO may not be terminated 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.

3.4 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 a Member leaves their job to perform military service, the Member has the right to elect to continue their 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 Member's military service, the Member has the right to be reinstated in their Group coverage when reemployed, without any Waiting Period or Preexisting Condition Exclusion Period except for service-connected illnesses or injuries. If a Member has any questions regarding USERRA, the Member should contact the plan administrator. The plan administrator determines eligible employees and provides that information to CareFirst.

C. District of Columbia Continuation of Health Coverage ("DCCHC").
This provision applies to Subscribers enrolled in an employer-maintained health benefit plan for less than twenty (20) employees.

1. The Subscriber and his or her Dependents covered under this Evidence of Coverage at the time eligibility for group coverage under this Evidence of Coverage is terminated have the right to continue coverage under the Group's contract for a period of three (3) months, unless:

   a. The Subscriber's employment was terminated for gross misconduct;

   b. The Member is eligible for any extension of coverage required under COBRA; or

   c. The Member fails to complete timely election and payment as provided below.

2. Duties of the Group.

   a. The Group shall furnish Subscribers whose coverage terminates written notification of the Subscriber's eligibility to continue coverage under DCCHC. Such notice shall be furnished no later than fifteen (15) days of the date coverage under this Evidence of Coverage would otherwise terminate. Failure by the Group to furnish the required notification shall not extend the right to continue coverage beyond the three-month period.

   b. The Group shall forward to CareFirst the names of Members who apply for DCCHC continuation of coverage within fifteen (15) days from the date of application.

3. Duties of the Subscriber.

   a. Individuals who elect coverage under this section shall bear the cost of the continued coverage for himself/herself and his or her Dependents and such cost shall not exceed one hundred two percent (102%) of the Group's rate.

   b. An individual who elects to continue coverage shall tender to the Group the amount described above within forty-five (45) days from the date coverage under this Evidence of Coverage would otherwise terminate.

4. Termination of Continued Coverage. Coverage under this provision shall continue without interruption for the continued eligibility period and shall not terminate unless:

   a. The Member fails to make timely payment of the required cost of coverage;

   b. The Member violates a material condition of this Evidence of Coverage;

   c. The Member becomes covered under another group health benefits plan that does not contain any exclusion or limitation with respect to any Preexisting condition that affects the Member;

   d. The Member becomes entitled to Medicare; or

   e. The Group no longer offers group coverage to any employee.

5. The Member shall be entitled to a Conversion Contract in accordance with Section 4 upon termination of his or her continued eligibility period as defined in this section.

3.5 Conversion Privilege. A Member may purchase a Conversion Contract upon expiration of the continuation of coverage.

3.6 Extension of Benefits. This provision applies if the Member is an inpatient in a hospital or skilled nursing facility on the date that the Group Contract terminates. If this provision applies, the Member may continue his or her coverage under the Group Contract until the first of the following:

A. The date the Member is discharged from the hospital or skilled nursing facility;

B. The date the Member is no longer, as determined by CareFirst, medically required to continue care as an inpatient;

C. The date that the Member became covered under a replacement coverage offered to the Member by the Group without limitation as to the condition for which he or she is an inpatient; or

D. 180 days following termination.

3.7 Effect of Termination. Except as provided in the Extension of Benefits section, no benefits will be provided for any services received on or after the date on which the Member's coverage terminates. This includes services received for an injury or illness that occurred before the effective date of termination.

3.8 Reinstatement. Coverage will not reinstate automatically under any circumstances.

SECTION 4
CONVERSION PRIVILEGE

4.1 Conversion Privilege

A. Group Conversion

1. A Member who has been covered under the Group Contract for at least three (3) months shall be eligible for a Conversion Contract without evidence of insurability.

2. If a Member is entitled to continue coverage through a Conversion Contract, CareFirst will notify the Member of the conversion option within sixty-one (61) days of the date coverage terminates. CareFirst must receive the Member's application form, including full payment of the applicable premium, within thirty-one (31) days after the effective date of termination, or within thirty-one (31) days following CareFirst's notice, whichever is later. However, if CareFirst does not notify the Member of this conversion privilege or there is a delay in giving this notice, the time period within which a Member can elect to convert will not extend beyond ninety (90) days following the termination date.

3. Conversion coverage is effective on the day following the date the Group Contract terminated or the Member's coverage under this Evidence of Coverage terminated.

4. Benefits under Conversion Contracts may vary from the benefits under this Evidence of Coverage and CareFirst reserves all rights, subject to applicable requirements of law, to determine the form and terms of the Conversion Contract(s) CareFirst issues.

B. Conversion Privilege Triggers

1. Subscriber No Longer Eligible for Group Coverage
If the Subscriber's coverage terminates because the Subscriber is no longer an employee or participant of the Group or no longer meets the Group's eligibility requirements for health benefits coverage, the Subscriber may purchase a Conversion Contract to cover himself/herself and his or her covered Dependents.

2. Upon Subscriber's Death
Following the death of a Subscriber, the enrolled Spouse and Dependent children or, if there is no Spouse the covered Dependent children of the Subscriber, may purchase a Conversion Contract.

3. Upon Termination of Marriage
If a Spouse's coverage terminates because of legal separation, divorce or because the marriage is legally annulled, the Spouse is entitled to purchase a Conversion Contract.

4. Upon Termination of Coverage of a Child
If coverage of a Dependent child terminates because the child no longer meets the eligibility requirements (e.g., the child marries, attains the Limiting Age, becomes capable of self-support, etc.) the child is entitled to purchase a Conversion Contract.

5. Upon Termination of the Group Contract by the Group
If coverage terminates because of the termination of the Group Contract by the Group, the Member may purchase a Conversion Contract if the Group has not provided for continued coverage through another health plan or other Group insurance program offered by or through the Group.

6. Upon Expiration of Continued Coverage
A Member may purchase a Conversion Contract upon expiration of continuation of coverage.

C. Exceptions

1. CareFirst will not issue a Conversion Contract if the Member is enrolled in a health maintenance organization, or is covered or eligible for coverage under another group policy which provides benefits substantially equal to the minimum benefits of the Conversion Contract.

2. CareFirst will not issue a Conversion Contract if:

   a. The person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy, or hospital or medical service subscriber contract, or medical practice, health maintenance organization, or other prepayment plan, or by any other plan or program;

   b. The person is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or whether the person is in the military service; or,

   c. Similar benefits are provided for or available to this person, pursuant to or in accordance with the requirements of any state or federal law.

3. CareFirst will not issue a Conversion Contract if benefits provided or available to the person under this section, together with the Conversion Contract, would result in over insurance according to CareFirst's standards on file with the Department of Insurance, Securities, and Banking.

4. CareFirst will not issue a Conversion Contract to a person eligible for Medicare, or continue coverage under a Conversion Contract beyond the date when the person is eligible for Medicare.

SECTION 5
COORDINATION OF BENEFITS ("COB"); SUBROGATION

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 looked at 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; but

   b. May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is described in the Effect on the Benefits section of this CareFirst Plan Evidence of Coverage.

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 sections 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 a nonprofit health service Plan, and those of a commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established or self-insured programs under which the insured may make a claim. The term Plan includes coverage under a governmental group, or coverage required or provided by law. This does not include a State group 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; or,

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

Primary Plan or Secondary Plan means the order of benefit determination rules state 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 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.

This rule described in 1) 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.

2) For a Dependent child whose parents are separated, divorced, or is 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 that actual knowledge of the terms of the court decree.

(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 set forth in 1) and 2) of this paragraph as if those individuals where parents of the child.

d. 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 which 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 a retiree and an 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.

e. 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, 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.

f. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber 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 that 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 Medicare Eligibility
This provision applies to Members who are enrolled in Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of 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 are paid by Medicare as primary, this CareFirst Plan will not duplicate those payments. 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).

2. Benefits under this CareFirst Plan will be coordinated as described above to the extent a benefit would have been provided or payable under Medicare if the Member had diligently sought to establish the Member's right to such benefits. Members shall agree to complete and submit to Medicare, CareFirst and/or Health Care Practitioners all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

5.3 Employer or Governmental Benefits
Coverage under this Evidence of 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 Veterans Administration, 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

A. 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. Subrogation applies to any illness or injury which is:

1. Caused by an act or omission of a third party; or

2. Covered under medical payment provisions of a liability or automobile policy issued to or otherwise covering the Member; or

3. Covered under a member's uninsured or underinsured policy issued to or otherwise covering the Member; or

4. Covered by No Fault Insurance. No Fault Insurance means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose.

B. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Evidence of Coverage, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst provided or will provide benefits. CareFirst may recover the amounts paid or will pay in benefits up to the amount received from or on behalf of the third party or applicable first party coverage. CareFirst will reduce the amount owed by the Member to CareFirst by CareFirst's pro-rata share of any attorneys' fees, court costs, or other costs the Member incurred in securing the payment.

C. CareFirst will have a lien on all funds the Member recovers up to the total amount of benefits provided. CareFirst may give notice of that lien to any party who may have contributed to the Member's loss.

D. CareFirst has the option to be subrogated to the Member's rights to the extent of the benefits provided under this Evidence of Coverage. This includes CareFirst right to bring suit or file claims against the third party in the Member's name.

E. Members agree to take action, furnish information and assistance, and execute such instruments that CareFirst may require while enforcing CareFirst rights under this section. The Member agrees to not take any action which prejudices CareFirst's rights and interests under this provision. If the Member does not cooperate with CareFirst administration of this provision, no benefits will be provided for the illness or injury. In addition, the Member will be responsible for any legal expense CareFirst incurs enforcing rights under this section.

F. There are two exceptions to the requirements of paragraphs A. through E.:

1. If the Group Contract has been issued to a Group whose principal office is located within Virginia, the exception applies to all Members of the Group.

2. If the Group Contract has been issued to any other Group, the exception applies only to Members who reside in Virginia.

When one of these two exceptions applies, the requirements of this paragraph will neither authorize CareFirst to subrogate, or require Members to consent to subrogation of his or her rights to recovery for personal injuries from third parties, except as may be permitted by law.

SECTION 6
GENERAL PROVISIONS

6.1 Claims and Payment of Claims

A. Claim Forms

CareFirst does not require a written notice of claims. 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 or to the Group for delivery to the 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 child subject to a Medical Child Support Order or Qualified Medical Support Order does not reside with the Subscriber, CareFirst will

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

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 the non-insuring parent, the provider of the Covered Services, or the appropriate child support enforcement agency of any State or the District of Columbia.

B. Proof of Loss

Written proof of loss shall be furnished to CareFirst within fifteen (15) months after the date of the loss. Failure to furnish the proof within the time required does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof is otherwise required.

C. Time of Payment of Claims

Benefits payable under this policy for will not be paid more than thirty (30) days after receipt of written proof of loss.

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 that owed CareFirst and CareFirst makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

E. Payment of Claims

Payment for services rendered by a Preferred Provider will be paid directly to the Preferred Provider rendering the services. If a Member receives Covered Services from any other provider, CareFirst reserves the right to pay either the Member or the provider. Such payment shall constitute full and complete satisfaction of CareFirst's obligation.

When a child Dependent is covered under a court or administrative order or a Qualified Medical Support Order and the parent who is not the Subscriber incurs covered expenses on the child Dependent's behalf, CareFirst reserves the right to make payment for these covered expenses to the non-Subscriber parent, the provider or the appropriate governmental agency. In any case, CareFirst's payment will be in full and complete satisfaction of CareFirst's obligation.

6.2 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 two (2) years from the date that written proof of loss is required to be submitted to CareFirst.

6.3 Delivery of Evidence of Coverage

Unless CareFirst makes delivery directly to the Member, CareFirst will provide to the Group, for delivery to each Member, a statement that summarizes the essential features of the coverage and states to whom benefits under the Evidence of Coverage are payable. Only one 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.

6.4 No Assignment

A Member cannot assign any benefits or payments due under this Evidence of Coverage to any person, corporation or other organization, except as specifically provided by this Evidence of Coverage or required by law.

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 in the Evidence of Coverage, 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 applicable law.

6.6 Identification Card

Any card CareFirst issues to the Member, under this Evidence of Coverage, is for identification only.

A. Possession of an identification card confers no right to benefits under this Evidence of Coverage.

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

C. Any person receiving benefits to which he or she is not entitled under the provisions of this Evidence of Coverage will be liable for the actual cost of such benefits.

6.7 Member Medical Records

It may be necessary to review and/or obtain medical records and information from hospitals, skilled nursing facilities, physicians or other practitioners who treat the Member. When a Member becomes covered under this Evidence of Coverage, the Member (or, 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 without limitation medical records and information requested to assist CareFirst in determining benefits and eligibility of Members.

6.8 Member Privacy

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

6.9 CareFirst's Relationship to Providers

Providers, including Preferred Providers, are independent individuals or organizations and 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. 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 Providers or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

6.10 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.

6.11 Administration of Evidence of Coverage

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

6.12 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), and/or the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) 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, and/or HIPAA, as applicable.

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 Rules for Determining Dates and Times

The following rules will be used when determining dates and times under the Group Contract:

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 Savings 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. Day means a calendar day, including weekends, holidays, etc., unless a different basis is specifically stated.

E. Year refers to calendar year, unless a different basis is specifically stated.

6.15 Notices

Whenever the terms of the Group Contract or Evidence of Coverage require the Member, CareFirst or the Group to "give notice" or "notify" another party, the following requirements apply:

A. To the Subscriber

Notices to Subscribers will be sent by mail to the most recent address for the Subscriber in CareFirst's files. The notice will be effective on the date mailed, whether or not the Subscriber in fact receives the notice or there is a delay in receiving the notice.

B. To CareFirst
When notice or payment 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

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 giving written notice to the Group.

6.16 Certificate of Creditable Coverage
CareFirst will furnish a written certificate of creditable coverage via first-class mail.

A. Termination of CareFirst Coverage Prior to Termination of Coverage under the Group

If an individual's coverage under this Group Contract ceases before the individual's coverage under the Group ceases, CareFirst will provide sufficient information to the Group (or to another party designated by the Group) to enable the Group (or other party), after termination of the individual's coverage under the Group, to provide a certificate that reflects the period of coverage under this Group Contract.

B. Individuals for Whom Certificate Must be Provided; Timing of Issuance

1. Issuance of Automatic Certificates

a. Qualified Beneficiaries Upon A Qualifying Event

In the case of an individual entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the individual would lose coverage in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. CareFirst will provide the certificate no later than the time a notice is required to be furnished for a qualifying event relating to notices required under COBRA.

b. Other Individuals When Coverage Ceases

In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the individual ceases to be covered under this Group Contract. CareFirst will provide the certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums).

If an individual's coverage ceases due to the operation of a Lifetime Maximum on all benefits, coverage is considered to cease on the earliest date that a claim is denied due to the operation of the Lifetime Maximum.

c. Qualified Beneficiaries When COBRA Ceases

In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), CareFirst will provide the certificate at the time the individual's coverage under the COBRA continuation coverage ceases. CareFirst will provide the certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). CareFirst will provide the certificate regardless of whether the individual has previously received a certificate under paragraph B.1.a of this section.

2. Any Individual Upon Request

CareFirst will provide a certificate in response to a request made by, or on behalf of, an individual at any time while the individual is covered under this Group Contract and up to twenty-four (24) months after coverage ceases. CareFirst will provide the certificate by the earliest date that CareFirst, acting in a reasonable and prompt fashion, can provide the certificate. CareFirst will provide the certificate regardless of whether the individual has previously received a certificate under paragraph B.1.b of this section.

C. Combining Information for Families

A certificate may provide information with respect to both a Subscriber and Dependents if the information is identical for each individual. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

6.17 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.

6.18 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.

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

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT A

BENEFIT DETERMINATIONS AND APPEALS

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 CareFirst, which afford CareFirst Members recourse pertaining to denials and reductions of claims for benefits by CareFirst.

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 CareFirst procedures.

An authorized representative may act on behalf of the Member in pursuing a benefit claim or appeal of an Adverse Benefit Determination. CareFirst may require reasonable proof to determine whether an individual has been properly authorized to act on behalf of a Member. In the case of a claim involving Urgent/Emergent Care, a Health Care Provider with knowledge of a Member's medical condition is permitted to act as the authorized representative.

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A. DEFINITIONS

Adverse Benefit Determination means, as used in this attachment, the following:

1. 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 this plan. An Adverse Benefit Determination includes a Rescission.

2. 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 Cosmetic, Experimental or Investigational, or not Medically Necessary or appropriate.

Health Care Provider means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Pre-Service Claim means any claim for a benefit when the receipt of the benefit, in whole or in part, is conditioned on the prior approval of the service in advance by CareFirst. These are services that must be "preauthorized" or "precertified" by CareFirst under the terms of the Member's contract.

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

Rescission means, as used in this attachment, 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/Emergent Care means a Pre-Service or Concurrent Care claim for medical care or with respect to which the application of the time periods for making non-Urgent/Emergent Care determinations:

1. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or,

2. 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 claim.

Whether a claim involves Urgent/Emergent Care is to be determined by an individual acting on behalf of CareFirst applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If a Health Care Provider with knowledge of the Member's medical condition determines that a claim involves Urgent/Emergent Care then CareFirst will treat the claim as one that involves Urgent/Emergent Care.

B. BENEFIT DETERMINATIONS

1. Request for Urgent/Emergent Care Coverage. When the Member or authorized representative requests a pre-service determination regarding Urgent/Emergent Care, then CareFirst will notify the Member or authorized representative of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, the earlier of:

   a. 24 hours after CareFirst's receipt of the necessary information to make the benefit determination, or

   b. 72 hours after receipt of the request for coverage.

   If a Member fails to provide sufficient information for CareFirst to determine whether benefits are covered or payable, CareFirst will notify the Member as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claims. 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. CareFirst will notify the Member of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

   a. CareFirst's receipt of the specified information, or

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

2. Pre-Service Claims. In the case of a Pre-Service Claim, CareFirst shall notify the Member of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

   This period may be extended one time by CareFirst for up to 15 days, provided that such an extension is necessary due to matters beyond the control of CareFirst and CareFirst 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 CareFirst expects to render a decision. 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 will have at least 45 days from receipt of the notice within which to provide the specified information.

In the case of a failure by a Member or authorized representative to follow CareFirst procedures for filing a Pre-Service Claim, the Member or authorized 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 or authorized representative, as appropriate, as soon as possible, but not later than 5 working days following the failure. Notice will be sent within 24 hours in the case of a failure to file a claim involving Urgent/Emergent Care. Notification may be oral, unless written notification is requested by the Member or authorized representative.

This paragraph shall apply only in the case of a communication:

a. By a Member or authorized representative that is received by CareFirst or its authorized agent customarily responsible for handling benefit matters; and,

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

3. Post-Service Claims. In the case of a Post-Service Claim, CareFirst shall notify the Member of the CareFirst's 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 by CareFirst for up to 15 days, provided that CareFirst both determines that such an extension is necessary due to matters beyond the control of CareFirst 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 CareFirst expects to render a decision. 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.

4. Concurrent Care Decisions. If CareFirst has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

a. CareFirst will notify the Member of any reduction or termination of such course of treatment (other than by a change in the plan's coverage by amendment or termination of coverage) before the end of such period of time or number of treatments and at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review before the benefit is reduced or terminated.

b. 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/Emergent Care will be decided as soon as possible, taking into account the medical exigencies. CareFirst will notify the Member of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made to CareFirst at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

5. Rescissions. If CareFirst has made an Adverse Determination that is a Rescission, CareFirst shall provide 30 days advance written notice to any covered person who would be affected by the proposed Rescission.

6. Calculating Time Periods. For purposes of this Part B, the period of time within which an Adverse Benefit Determination is required to be made shall begin at the time a claim is filed in accordance with CareFirst procedures. The time is counted regardless to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended 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.

C. INTERNAL GRIEVANCE PROCEDURE

1. A grievance must be filed within 180 days from the date of receipt of the written notice of any Adverse Benefit Determination.

2. A Member or authorized representative should first contact CareFirst about a denial of benefits. CareFirst can provide information and assistance on how to file a grievance. All grievances filed should be in writing, except grievances involving Urgent/Emergent Care which may be submitted orally or in writing.

3. The Member or authorized representative may submit written comments, documents, records, and other information relating to a claim for benefits.

4. The grievance decision for Urgent/Emergent Care claim shall be made as soon as possible but no later than the earlier of 24 hours after CareFirst's receipt of the necessary information to make the decision regarding request for coverage, or 72 hours after receipt of the request for coverage.

5. 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. A document, record, or other information shall be considered relevant to a Member's claim if it:

   a. Was relied upon in making the benefit determination;

   b. 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; or,

   c. Demonstrates compliance with the administrative processes and safeguards designed to ensure and verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated members.

6. A grievance and any applicable documentation should be sent to the correspondence address stated on the reverse of the Member identification card.

7. Timing of CareFirst responses. The time limits for responding to a grievance will begin at the time an appeal is filed in accordance with these procedures, without regard to whether all the information necessary to make a decision is initially included. CareFirst will make a grievance decision and written notification will be sent:

   a. Within 30 days after receipt of the grievance for a case involving a Pre-Service Claim;

b. Within 60 days after receipt of the grievance for a case involving a Post-Service Claim; and

In the case of an expedited appeal regarding a claim relating to a prescription for the alleviation of cancer pain, the appeal decision shall be made as soon as possible but no later than 24 hours after receipt of the appeal.

8. When more information is needed for a decision. CareFirst will send notice within 5 working days of the receipt of the appeal that it cannot proceed with its review unless the additional information is provided. CareFirst will assist in gathering the necessary information. The response deadlines described above may be extended one time by CareFirst for up to 15 days, provided that CareFirst both:

   a. determines that such an extension is necessary due to matters beyond the control of CareFirst; and,

   b. 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 CareFirst expects to render a decision.

   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.

   In the event that a period of time is extended due to a Member's failure to submit necessary information, the period for responding to a grievance 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.

   The Member must agree to this extension in writing. The Member will be asked to sign a consent form.

D. FAIR AND FULL REVIEW

CareFirst will provide a review that:

1. Takes 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;

2. Does not afford deference to the initial Adverse Benefit Determination and is conducted by an appropriate named fiduciary of CareFirst who is neither the individual who made the Adverse Benefit Determination that is subject to the appeal, nor the subordinate of such individual;

3. In deciding an appeal of an 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 Cosmetic, Experimental/Investigational, or not Medically Necessary, the appropriate named fiduciary shall consult with a Health Care Provider who has appropriate training and experience in the field of medicine involved in the medical judgment;

4. Provides for the identification of medical or vocational experts whose advice was obtained on behalf of CareFirst in connection with a Member's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and,

5. The Health Care Provider engaged for purposes of a consultation is an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination, nor the subordinate of any such individual.

E. DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEAL PROCESS

In the case of a plan that fails to adhere to the minimum requirements for employee benefit plan procedures relating to Claims for Benefits, the Member is deemed to have exhausted the internal claims and appeals processes of paragraph C and D herein. Accordingly the Member may initiate an external review under paragraph F of this section, as applicable. The Member is also entitled 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 chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the Claim for Benefits or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

F. EXTERNAL APPEAL PROCEDURE

A Member who is dissatisfied with a decision rendered in a final internal grievance process shall have the opportunity to pursue an appeal before an external independent review organization if filed within four (4) months of the final grievance decision.

If a Member is dissatisfied with the resolution reached through CareFirst's internal grievance system regarding medical necessity, the Member may contact the Director, Office of Health Care Ombudsman and Bill of Rights, at the following:

District of Columbia Department of Health Care Finance
Office of Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th St. NW, 900 South
Washington, DC 20001
((877) 685-6391; (202) 442-6724 or fax (202) 478-1397)

If a Member is dissatisfied with the resolution reached through CareFirst's internal grievance system regarding all other grievances, the Member may contact the Commissioner at the following:

Commissioner, Department of Insurance, Securities and Banking
810 First St. N.E., 7th Floor
Washington, D.C. 20002
(202) 727-8000
Fax: (202) 354-1085

A Member shall also have the option to contact the District of Columbia Department of Insurance, Securities and Banking to request an investigation or file a complaint with the Department at any time during the internal claims and appeal process.

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

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT B
DESCRIPTION OF COVERED SERVICES

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 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 Limit and other features that affect Member coverage, including specific benefit limitations and, if applicable, the Lifetime Maximum.

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer

SECTION 1
GENERAL PROVISIONS

1.1 Benefits Under the Preferred Provider Plan

The Preferred Provider Plan offers two (2) levels of benefits. Members may select the benefit level at which coverage will be provided each time care is sought. Under the Preferred Provider Plan, Members may receive benefits for a particular service under either the In-Network component or the Out-of-Network component. Members 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 Out-of-Network benefits apply. In-Network benefits apply in the following circumstances:

1. Services Rendered by a Preferred Provider

Benefits for services rendered by a Preferred Provider are based on the appropriate Allowed Benefit, as described in the Evidence of Coverage. The level of benefits is reflected under In-Network Benefits in the Schedule of Benefits. Preferred Providers will submit claims to CareFirst directly for Covered Services. The Preferred Provider will accept one hundred percent (100%) of the Allowed Benefit as full payment for Covered Services.

2. Services Rendered by an Exempt Provider

Benefits for services rendered by an Exempt Provider are based on the appropriate Allowed Benefit for the service or supply provided. The level of benefits is reflected under In-Network Benefits in the Schedule of Benefits. The Member may be responsible for amounts in excess of the Allowed Benefit, in addition to any applicable Deductibles, Coinsurance and/or Copayments.

3. Other Circumstances

In each of the following circumstances, benefits will be based on the appropriate Allowed Benefit for the service or supply provided. The level of benefits for these providers' services will be that shown under In-Network Benefits in the Schedule of Benefits. The Member may be responsible for amounts in excess of the Allowed Benefit, in addition to any applicable Deductibles, Coinsurance and/or Copayments.

a. The Member's Preferred Provider refers the Member to a provider who is not a Preferred Provider.

b. The Member receives covered Emergency Services (as defined in the Evidence of Coverage) from a provider who is not a Preferred Provider.

c. A Preferred Provider is not reasonably available.

B. Out-of-Network Benefits

Out-of-Network benefits apply when the Member obtains Covered Services from a provider who is not a Preferred Provider, an Exempt Provider, or in circumstances not addressed in above under In-Network Benefits. When Out-of-Network benefits apply, the Member will receive reduced benefits for Covered Services. The benefit will be based on the appropriate Allowed Benefit. The level of benefits provided is reflected under Out-of-Network Benefits in the Schedule of Benefits. The Member may be responsible for amounts in excess of the Allowed Benefit for these services, in addition to any applicable Deductibles, Coinsurance and/or Copayments.

1.2 Limitation on Provider Coverage

Services are covered only if the provider is an Eligible Provider. The provider must be licensed in 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;

B. The Member him/herself, or by the Member's Spouse, mother, father, daughter, son, brother, or sister; or,

C. Anyone who resides in the Member's home.

1.3 Cost Sharing and Maximum Amounts

The terms Deductible, Coinsurance, Copayment, Out-of-Pocket Limits, and Lifetime Maximum are defined in the Evidence of Coverage. The Schedule of Benefits provides additional information including the amounts, an explanation of how these features apply to In-Network and Out-of-Network services, and a listing of the services that are subject to them.

Coinsurance	For most Covered Services, once the Deductible is met (or for services without a Deductible), costs are shared between CareFirst and the Member based on the Coinsurance percentage of the Allowed Benefit that CareFirst must pay and that the Member must pay.
Copayment	A Copayment is similar to coinsurance, except that Copayments are set at a fixed dollar amount, rather than as a percentage of the Allowed Benefit.
Deductible	The Deductible will be calculated based upon the Benefit Period of the Member's coverage. Under the Preferred Provider Plan, there may be a single Deductible for In-Network and Out-of-Network services or separate Deductibles that apply to each. For most Covered Services, Members do not begin to receive benefits until they meet their Deductible.
Lifetime Maximum	If a Lifetime Maximum applies and the Member reaches the Lifetime Maximum, the Member will thereafter have either no benefit or only a limited "Annual Restoration Benefit." The Schedule of Benefits provides further information on the Lifetime Maximum.
Out-of-Pocket Limits	Once the Member meets the Out-of-Pocket Limit, the Member may no longer be required to pay his or her share of the Copayments, Coinsurance, or Deductibles for the remainder of that Benefit Period for any services that are subject to the Out-of-Pocket Limit. Under the Preferred Provider Plan, there may be a single Out-of-Pocket Limit for In-Network and Out-of-Network services, or separate Out-of-Pocket Limits that apply to each.

SECTION 2
OUTPATIENT AND OFFICE SERVICES

2.1 Office Visits
Benefits are available for office visits for diagnosis and treatment of a medical condition, including care and consultation by primary care physicians and specialists.

2.2 Diagnostic Procedures, Laboratory Tests, and X-Ray Services
Coverage is provided for the following diagnostic procedures, laboratory tests, and x-ray services, including:

A. Electrocardiogram;

B. Laboratory services; and

C. Diagnostic x-ray services, diagnostic ultrasound services.

2.3 Preventive Services
Benefits for preventive care include the following:

A. Well Child Care
Benefits are available for infants, children, and adolescents (newborn up to age twenty-one (21)) for:

1. Each office visit in which a childhood or adolescent immunization, recommended by the Advisory Committee on Immunizations Practices of the Center for Disease Control, is administered, and the cost of the immunization.

Visits for the collection of adequate samples for hereditary and metabolic newborn screening and follow-up between birth and four (4) weeks of age, the first of which is to be collected before two (2) weeks of age.

3. Coverage for newborn hearing screening consisting of one of the following tests: auditory brain stem response; otoacoustic emissions; or, other appropriate, nationally recognized, objective physiological screening test.

Additionally, benefits will be provided for infant hearing screenings and all necessary audiological examinations provided using any technology approved by the United States Food and Drug Administration, and as recommended by the most current standards addressing early hearing detection and intervention programs by the National Joint Committee on Infant Hearing. Such coverage shall include follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss. Infant as used here is defined according to the most current recommendation of the American Academy of Pediatrics.

4. Visits for and costs of age appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics.

5. Examinations including developmental assessments and parental anticipatory guidance.

6. Laboratory tests necessary to provide these services.

B. Routine Gynecological (GYN) Exam and Adult Routine Physical Exam (for a Member at the age specified in the Schedule of Benefits.

C. Cancer Screening Services
Benefits are available for the following cancer screening services.

1. Prostate Cancer Screening
Benefits are available for prostate cancer screenings when rendered in accordance with the latest guidelines issued by the American Cancer Society and include a medically recognized diagnostic examination, a digital rectal exam and the Prostate-Specific Antigen (PSA) Test.

2. Pap Smear
Benefits are available for pap smears, at intervals appropriate to the Member's age and health status, as determined by CareFirst.

3. Mammography
Benefits are available for mammograms, at intervals described in the Schedule of Benefits. Services must be prescribed by the Member's physician and rendered in facilities or programs that meet the standards set by the American College of Radiology for Mammography, or as defined by CareFirst. Such standards include provisions for equipment, staffing, interpretation, supervision, and radiation levels used for screening mammography.

4. Colorectal Cancer Screening
Benefits are available for medically recognized diagnostic examination in accordance with the most recently published guidelines issued by the American College of Gastroenterology, in consultation with the most current American Cancer Society guidelines appropriate for age, family history and frequency.

2.4 Allergy Testing and Treatment
Benefits are available for allergy testing and treatment, including the administration of injections and allergy serum.

2.5 Rehabilitation Services

A. Definitions

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

Occupational Therapy (OT) means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition. Occupational Therapy services do not include the adjustment or manipulation of any of the osseous structures of the body or spine.

Speech Therapy (ST) means the treatment of communication impairment and swallowing disorders. Speech Therapy services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation, including cognitive rehabilitation.

Rehabilitation Practitioners means Physical Therapists, Speech Therapists, Occupational Therapists and Chiropractors

B. Covered Benefits
Benefits are available for Occupational Therapy, Speech Therapy, or Physical Therapy for conditions that CareFirst determines are subject to improvement.

C. Limitations and Conditions
Prior authorization is not required for Physical Therapy, Occupational Therapy, or Speech Therapy services or for any other service provided by the same provider on the same day as these services.

2.6. Spinal Manipulation

A. Covered Benefits
Coverage shall be provided for Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a licensed chiropractor, doctor of osteopathy (D.O.) or other eligible practitioner. Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine. Spinal Manipulation services are limited to Members who are twelve (12) years of age or older.

B. Limitations and Conditions
Prior authorization is not required for chiropractic services, or for any other service provided by the same provider on the same day as these services.

2.7 Habilitative Services for Children

A. Covered Benefits
Habilitative Services are services, including Occupational Therapy, Physical Therapy, and Speech Therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. This includes a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defects include, but are not limited to, autism or an autism spectrum disorder, and cerebral palsy.

Benefits for Habilitative Services are available for Dependent children under the age of twenty-one (21) years and include Occupational Therapy, Physical Therapy, and Speech Therapy.

B. Conditions and Limitations
Benefits are not covered for Habilitative Services delivered through early intervention or school services. Prior authorization is required.

Benefits are not counted toward any visit maximum for Physical Therapy, Occupational Therapy or Speech Therapy services stated in the Schedule of Benefits.

2.8 Therapeutic Treatment Services
Benefits are available for treatment and therapeutic services in connection with a covered procedure, including chemotherapy, electroshock therapy, radiation therapy, and radioisotope services. Benefits for high dose chemotherapy are limited to the description stated in Section 2.15, 14 High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant.

2.9 Blood and Blood Products
Benefits are available for blood and blood products (including derivatives and components) that are not replaced by or on behalf of the Member.

2.10 Outpatient Surgical Procedures
Benefits are available for surgical procedures performed by Health Care Practitioners on an outpatient basis.

2.11 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, the anesthesia must be administered by a Health Care Practitioner other than the operating surgeon or assistant at surgery. For example, a local anesthetic used while performing a medical or surgical procedure is not generally viewed as a separately covered charge

2.12 Outpatient Care

Benefits are available for the following outpatient services rendered in the outpatient department of a hospital or in an ambulatory surgical facility, or other facility in connection with a medical or surgical procedure covered under the Outpatient and Office Services Section of this Description of Covered Services.

A. Use of operating room and recovery room;

B. Use of special procedure rooms;

C. Laboratory, x-ray and machine tests;

D. Hemodialysis;

E. Chemotherapy and radiation therapy (benefits for high dose chemotherapy are limited to that stated in the High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant Section of this Description of Covered Services);

F. Cardiac Rehabilitation

1. Covered Benefits
Cardiac Rehabilitation benefits are provided to Members who have been diagnosed with significant cardiac disease, as defined by CareFirst, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst.

2. Conditions and Limitations
Services must be provided at a CareFirst approved place of service equipped and approved to provide Cardiac Rehabilitation. Benefits will not be provided for maintenance programs.

2.13 Transplants

A. Covered Benefits
Benefits for all Medically Necessary, non-Experimental/Investigational bone marrow, solid organ transplant, and other non-solid organ transplant procedures are covered, as determined by CareFirst. Prior authorization is required for transplant services. Prior authorization will be granted only upon receipt of a written request from a physician.

B. Covered Services include the following:

1. The Allowed Benefit 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 if approved by CareFirst.

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 to the extent that the services are not covered under any other health insurance plan or contract. Donor Services consist of services covered under the Evidence of Coverage which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure, which are directly related to donating the organ or tissue.

6. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant. The cost of these drugs will not be counted towards any Prescription Drug benefit maximum under any rider attached to this Evidence of Coverage.

C. Conditions and Limitations
Benefits are only available upon receipt of a written request from a physician and if determined to be Medically Necessary, non-Experimental/Investigational, and appropriate by CareFirst given due consideration to the general health status, age, and prognosis for significant improvement of the general health status of the Member following the transplant procedure. The Physician must certify that alternative procedures, services, or courses of treatment would not be effective in the treatment of the Member's condition.

2.14 High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant
Benefits will be provided for high dose chemotherapy/bone marrow or stem cell transplant treatment that is not Experimental/Investigational as determined by CareFirst. Prior authorization is required for transplant services. Prior authorization will be granted only upon receipt of a written request from a physician.

2.15 Clinical Trial Patient Cost Coverage

A. Definitions

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.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal 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.

Patient Cost means the cost of a Medically Necessary health care service that is Incurred as a result of the treatment being provided to the Member for purposes of the clinical trial. Patient Cost does not include the cost of an Investigational drug or device, cost of non-health care services that a Member may be required to receive as a result of the treatment being provided for purposes of the clinical trial, costs associated with managing the research associated with the clinical trial, or costs that would not be covered under this Evidence of Coverage for non-Investigational treatments.

B. Covered Services

1. Benefits for Patient Cost to a Member in a clinical trial will be provided if the Member's participation in the clinical trial is the result of:

   a. Treatment provided for a life-threatening condition; or,

   b. Prevention, early detection, and treatment studies on cancer.

2. Coverage for Patient Cost will be provided only if:

   a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or,

   b. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening condition;

   c. The treatment is being provided in a clinical trial approved by one of the National Institutes of Health, an NIH Cooperative Group, an NIH Center, the FDA in the form of an Investigational new drug application, the federal Department of Veterans Affairs, or 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;

   d. 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;

   e. There is no clearly superior, non-Investigational treatment alternative; and,

   f. 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.

3. 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.

2.16 Maternity and Related Services

Maternity benefits may contain a limited maximum benefit under this Evidence of Coverage as stated in the Schedule of Benefits.

A. Obstetrical care for a normal pregnancy, an ectopic pregnancy, miscarriage or complications of pregnancy, including cesarean section if medically indicated, abortion, or delivery, including prenatal care and postnatal care.

B. Routine newborn care while the mother is hospitalized for covered maternity care provided the mother is a Member and eligible for maternity benefits. Coverage is limited to routine newborn visits (not to exceed two visits) and male circumcision. To qualify for coverage of other services, the newborn must be a Member in his or her own right.

C. Inpatient postpartum treatment and postpartum home visits as described in Section 5.3 B, of this Description of Covered Services.

D. Voluntary sterilization of adult Members and surgical reversal of voluntary sterilization procedures.

E. Dilation and curettage (D&C) or full term pregnancy for any female Member (including a Dependent) who became pregnant as the result of rape or incest.

2.17. Infertility Services
Benefits are available for the diagnosis of infertility. Benefits are limited to the following:

A. Infertility Counseling

B. Testing

2.18 Diabetes Equipment, Supplies, and Self-Management Training

A. Coverage will be provided for all Medically Necessary and medically appropriate equipment, diabetic supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

B. If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified Health Care Provider whose scope of practice includes diabetes education or management.

2.19 Dental Services

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 6 months of the injury, treatment began within 6 months of the earliest date that it would be medically appropriate to begin such treatment.

2. Conditions and Limitations
Benefits are limited to Medically Necessary dental services as a 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 above, or in Section 2.19 B, describing benefits for the treatment of cleft lip and cleft palate, dental care is excluded from coverage. Benefits for oral surgery are described below.

B. 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.

2.20 Oral Surgery

A. Benefits for oral surgery include:

1. Medically Necessary procedures, as determined by CareFirst, to attain functional capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or exostoses, or drain abscesses with cellulitis and which are performed on teeth and supporting structures, lips, tongue, roof and floor of the mouth, accessory 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 teeth and supporting structures or the need for oral surgical services or dental services for 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.

3. Medically necessary oral surgical services for the treatment of cleft lip or cleft palate or both.

B. Medically Necessary surgical treatment, as determined by CareFirst, for Temporomandibular Joint Syndrome (TMJ). 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.

2.21 Reconstructive Breast Surgery

A. Definitions

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

Reconstructive Breast Surgery means surgery performed as a result of a Mastectomy to reestablish symmetry between two breasts. Reconstructive Breast Surgery includes augmentation mammoplasty, reduction mammoplasty and mastoplexy.

B. Covered Benefits
Coverage will be provided for all stages of Reconstructive Breast Surgery of the breast on which a Mastectomy was performed, for all stages of surgery and reconstruction of the non-diseased breast to establish symmetry with the diseased breast when Reconstructive Breast Surgery on the diseased breast is performed, and for breast prostheses and services resulting from physical complication at all stages of Mastectomy, including lymphedemas.

2.22 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.

2.23 Emergency Services
Benefits are available for Emergency Services received in or through a hospital emergency room.

2.24. Limited Service Immediate Care. 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. Limited Service Immediate Care services are non-emergency and non-urgent services. Services are provided in Limited Service Immediate Care Centers, which are mini-medical office chains typically staffed by nurse practitioners with an on-call physician. Examples of common ailments for which a reasonable, prudent layperson who possesses an average knowledge of health and medicine would seek Limited Service Immediate Care, include but are not limited to: ear, bladder, and sinus infections; pink eye; flu; and strep throat.

2.25 Ambulance Services

Benefits are available for Medically Necessary ambulance services to or from the nearest appropriate hospital.

If the Member is outside the United States and requires treatment by a medical professional, benefits will be provided to transport the member to the nearest location where more appropriate medical care is available. Benefits include air and ground ambulance services, when Medically Necessary.

2.26 Osteoporosis Prevention and Treatment Services

A. 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 means a Member:

1. Who is estrogen deficient and at clinical risk for osteoporosis;

2. 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;

3. Receiving long-term glucocorticoid (steroid) therapy;

4. With primary hyperparathyroidism; or,

5. Being monitored to assess the response to, or efficacy of, an approved osteoporosis drug therapy.

B. 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.

SECTION 3
INPATIENT HOSPITAL SERVICES

3.1 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. 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

Inpatient physician and medical services provided by or under the direction of the attending Health Care Practitioner, including:

1. Inpatient Health Care Practitioner visits.

2. Consultations by Health Care Practitioner Specialists.

3. Intensive care services.

4. Rehabilitation Services.

5. Respiratory therapy, radiation therapy and chemotherapy services.

6. Anesthesia services and supplies.

7. Diagnostic procedures, laboratory tests and x-ray services.

8. Medically Necessary inpatient Ancillary Services rendered to the Member.

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 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.

3.2 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. Hospitalization for Rehabilitation

Benefits are provided for an admission or transfer to a CareFirst approved facility for rehabilitation. Benefits provided during any confinement will not exceed the benefit limitation, if any, stated in the Schedule of Benefits. As used in this paragraph, a confinement means a continuous period of hospitalization or two or more admissions separated by thirty (30) days. This limit on hospitalization applies to any portion of an admission that:

1. Is required primarily for Physical Therapy or other rehabilitative care; and

2. Would not be Medically Necessary based solely on the Member's need for inpatient acute care services other than for rehabilitation.

B. 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 for the treatment of breast cancer.

C. Hysterectomies

Coverage will be provided for vaginal hysterectomies and abdominal laparoscopy-assisted vaginal 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 Practitioner, the Member may elect to stay less than the minimum prescribed above when appropriate.

D. 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 the minimum hospital stays listed above.

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 Health Care Practitioner may agree to an early discharge.

3.3 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 4
SKILLED NURSING FACILITY SERVICES

4.1 Covered Skilled Nursing Facility Services

A. Definitions

Custodial Care is care that does not require the continuing attention of trained medical personnel. This includes any service that can be learned and provided by an average individual who does not have medical training.

Qualified Skilled Nursing Facility means a licensed facility that is approved for participation as a Skilled Nursing Facility under Medicare, certified as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations, its successor, or the applicable state regulatory agency. 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. Inpatient skilled nursing is for those 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.

Skilled Nursing Care means non-Custodial Care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

B. Covered Benefits

The services listed below are covered only in a Qualified Skilled Nursing Facility during a CareFirst-approved confinement. Coverage for Qualified Skilled Nursing Facility services is subject to CareFirst certification of the need for Qualified Skilled Nursing Facility confinement and the appropriate length of stay for such confinement in accordance with CareFirst utilization management requirements.

1. Room and board in a semiprivate room;

2. The following inpatient physician and medical services if CareFirst determines that the Health Care Practitioner rendered services to the Member and such services were medically required to diagnose or treat the Member's condition:

   a. Health Care Practitioner visits during the hospital stay, one (1) per day. Benefits are available for more than one (1) inpatient visit per day if warranted by the complexity of the medical condition.

   b. Consultation by another Health Care Practitioner when additional skilled care is required because of the complexity of the Member's condition.

3. Services and supplies ordinarily furnished by the facility to inpatients for diagnosis or treatment, including:

   a. Use of special equipment in the facility;

   b. Drugs, medications, solutions, biological preparations, and medical supplies used while the Member is an inpatient in the facility.

4.2 Conditions for Coverage

Qualified Skilled Nursing Facility care must be authorized or approved by CareFirst as meeting the following conditions for coverage:

A. The admission to a Qualified Skilled Nursing Facility must be a substitute for hospital care (i.e., if the Member were not admitted to a Qualified Skilled Nursing Facility, he or she would have to be admitted to a hospital).

B. The Member must require Skilled Nursing Care or skilled Rehabilitation Services which are:

1. Required on a daily basis;

2. Not Custodial Care; and,

3. Only provided on an inpatient basis.

C. The admission and continued confinement must be certified by CareFirst as meeting the criteria for coverage.

4.3 Custodial Care

Benefits will not be covered under this Evidence of Coverage for any Covered Services, including Qualified Skilled Nursing Facility care and Home Health Care, for any visits or services that CareFirst determines were provided primarily for Custodial Care.

A. Examples of Custodial Care include:

1. Assistance in performing the activities of daily living, such as feeding, dressing, and personal hygiene;

2. Administration of oral medications, routine changing of dressing, or preparation of special diets; and,

3. Assistance in walking or getting in or out of bed.

B. Services may be deemed Custodial Care even if:

1. The Member cannot provide this care for himself or herself because of age or illness;

2. There is no one in the Member's household who can perform these services for the Member;

3. The care is ordered by a physician;

4. The care is necessary to maintain the Member's present condition; or,

5. Covered by Medicare.

SECTION 5
HOME HEALTH SERVICES

5.1 Covered Home Health Services

A. Definitions

Home Health Care means the continued care and treatment of a Member in the home by a licensed Home Health Agency if:

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

2. The Plan of Treatment covering the Home Health Care service is established and approved in writing by the Health Care Practitioner, and determined to be Medically Necessary by CareFirst.

Home Health Care Visits

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

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

Qualified Home Health Agency means a licensed program which is a Preferred Provider, 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.

Skilled Nursing Care means non-Custodial Care that requires licensure as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

5.2 Limitations

Home Health Services must be authorized or approved by CareFirst as Medically Necessary under the utilization management requirements as meeting the following conditions for coverage:

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 Rehabilitation Services to sick, disabled, or injured persons.

B. The Home Health Care Visits must be a substitute for hospital care or for care in a Qualified Skilled Nursing Facility (i.e., if Home Health Care Visits were not provided, the Member would have to be admitted to a hospital or Qualified Skilled Nursing Facility).

C. The Member must require and continue to require Skilled Nursing Care or Rehabilitation Services in order to qualify for home health aide services or other types of Home Health Care.

D. The need for home health services must not be Custodial Care in nature (see Section 10, Exclusions and Limitations).

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.

5.3 Number of Home Health Visits.

A. Home Health Visits Following Mastectomy or Surgical Removal of a Testicle. For a Member who receives less than 48 hours of inpatient hospitalization following a mastectomy or the surgical removal of a testicle, or who undergoes a mastectomy or 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.

B. 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 3.2.D, Number of Hospital Days Covered, benefits will be provided for:

a. one (1) home visit scheduled to occur within twenty-four (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 3.2.D, Number of Hospital Days Covered, benefits will be provided for a home visit if prescribed by the attending provider.

3. Home visits will be provided in accordance with generally accepted standards of nursing practice for home care of the mother and newborn child, be provided by a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health, and include any services required by the attending provider.

4. Refer to the Schedule of Benefits for applicability of Copayments, Coinsurance and Deductibles to this benefit.

C. All other Home Health Visits will be provided up to the maximum visit limit, if any, stated in the Schedule of Benefits.

SECTION 6
HOSPICE SERVICES

6.1 Covered Hospice Services

A. Definitions

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.

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.

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.

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

Qualified Hospice 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 individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement period.

B. Covered Benefits

Benefits will be provided for the services listed below when provided by a Qualified Hospice 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.

1. Intermittent nursing care by or under the direction of a registered nurse;

2. Medical social services for the terminally ill patient and his or her Immediate Family;

3. Counseling, including dietary counseling, for the terminally ill Member;

4. Non-Custodial Home Health Care Visits as described in Section 5 Home Health Care Services of this Description of Covered Services;

5. 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;

6. Laboratory test and x-ray services;

7. Medically Necessary ground ambulance services, as determined by CareFirst;

8. Family Counseling and Bereavement Counseling will be provided to the Immediate Family of the deceased patient when authorized or approved by CareFirst. Benefits are subject to the limitations in the Schedule of Benefits.

6.2 Conditions for Coverage

Hospice services must be certified by CareFirst, provided by a Qualified Hospice 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 Program;

D. 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.

6.3 Hospice Eligibility Period

The hospice eligibility period begins on the first date hospice 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.

SECTION 7
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

7.1 Definitions. The following terms have the meanings described below:

Alcohol Abuse means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Clinically Significant means sufficient to impair substantially a person's judgment, behavior, capacity to recognize, or ability to cope with the ordinary demands of life.

Drug Abuse means any pattern of pathological use of drugs that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Inpatient Services mean therapeutic services and supplies that are Medically or Psychologically Necessary and that are provided in a hospital or Non-Hospital Residential Facility to a patient according to an individualized treatment plan that requires the patient to be admitted.

Medically or Psychologically Necessary means essential for the treatment of Drug Abuse, Alcohol Abuse, or Mental Illness as determined by a physician, psychologist or social worker; or as determined by the Plan.

Mental Illness means any mental disorder, mental illness, psychiatric illness, mental condition or psychiatric condition (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Non-Hospital Residential Facility means a facility certified by the District of Columbia or by any jurisdiction in which it is located as a qualified non-hospital provider of treatment for Drug Abuse, Alcohol Abuse, Mental Illness, or any combination of these, in a residential setting. The term Non-Hospital Residential Facility includes any facility operated by the District, any state or territory, or the United States to provide these services in a residential setting. A Non-Hospital Residential Facility also must meet or exceed guidelines established for such a facility by us and as amended from time to time. It is not a facility licensed as a general or special hospital.

Outpatient Services mean therapeutic services and supplies that are Medically or Psychologically Necessary, and which are provided to a patient according to an individualized treatment plan that does not require the patient to be admitted to a hospital or Non-Hospital Residential Facility. The term Outpatient Services refers to services and supplies that may be provided in a hospital, a Non-Hospital Residential Facility, an Outpatient Treatment Facility or a Health Care Practitioner's office.

Outpatient Treatment Facility means a clinic, counseling center, or other similar location that is certified by the District of Columbia, or by any jurisdiction in which it is located as a qualified provider of outpatient services for the treatment of Drug Abuse, Alcohol Abuse, or Mental Illness. The term Outpatient Treatment Facility includes any facility operated by the District, any state or territory, or the United States to provide these services on an outpatient basis.

Partial Hospitalization means the provision of medically directed intensive or intermediate short-term treatment in a licensed or certified facility or program for treatment of Mental Illnesses, Drug Abuse and/or Alcohol Abuse.

Qualified Partial Hospitalization Program means a licensed or certified facility or program that provides medically directed intensive or intermediate short-term treatment for Mental Illness, Drug Abuse and/or Alcohol Abuse for a period of less than twenty-four (24) hours, but more than four (4) hours in a day.

Quarterway House means a residential facility for people who show the effects of Alcohol or Drug Abuse in which further use of alcohol or drugs is prevented and the pain caused by withdrawal is relieved.

Rehabilitation Home means a residential facility for people who show the effects of Alcohol Abuse or Drug Abuse and would be helped by a residential rehabilitation program.

Therapy Service means services rendered by an Eligible Provider to rehabilitate a Member who shows the effects of Alcohol Abuse and/or Drug Abuse including: psychotherapy; counseling; family therapy; drug therapy; behavior therapy; occupational therapy; and recreational therapy.

Treatment Facility means an Outpatient Treatment Facility, Quarterway House, Non-Hospital Residential Facility, Rehabilitation Home or hospital which operates a rehabilitation program for people who show the effects of Alcohol Abuse or Drug Abuse. For the purposes of the diagnosis, care and treatment of Mental Illness, the term Treatment Facility means a hospital, Non-Hospital Residential Facility or Outpatient Treatment Facility only. It must be licensed or certified by the proper authority in the area where the facility is located.

7.2 Outpatient Mental Health and Substance Abuse Services

To be eligible for benefits, a Health Care Practitioner must certify that the Member is suffering from a Clinically Significant Mental Illness, Alcohol Abuse and/or Drug Abuse and prescribe Medically or Psychologically Necessary treatment (which may include referral to another Eligible Provider). Covered Services include:

A. Benefits are available for Outpatient Services (as described above) rendered by an Eligible Provider for the Medically or Psychologically Necessary treatment of Clinically Significant Mental Illness, Alcohol Abuse and/or Drug Abuse.

B. Benefits are available for Partial Hospitalization (as described above) services rendered in a Qualified Partial Hospitalization Program. Coverage for Partial Hospitalization is subject to CareFirst certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements.

C. Benefits are available for diagnosis and treatment for Alcohol Abuse and/or Drug Abuse, including outpatient detoxification and rehabilitative services in a covered alcohol or drug rehabilitation program or Qualified Partial Hospitalization Program. Members must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by CareFirst.

D. Office visits for medication management in connection with Mental Illness, Alcohol Abuse and/or Drug Abuse will be covered on the same basis as other covered medical conditions.

7.3 Inpatient Services Mental Health and Substance Abuse Services

To be eligible for benefits, a Health Care Practitioner must certify that the Member is suffering from a Clinically Significant Mental Illness, Alcohol Abuse and/or Drug Abuse and prescribe Medically or Psychologically Necessary treatment (which may include referral to another Eligible Provider). Coverage for Inpatient Services is subject to CareFirst certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements. Covered Services include:

A. Benefits are available for Inpatient Services (including Therapy Services as described above) rendered by an Eligible Provider for the Medically or Psychologically Necessary treatment of Clinically Significant Mental Illness, Alcohol Abuse and/or Drug Abuse.

B. Benefits are available for diagnosis and treatment for Alcohol Abuse and/or Drug Abuse, including inpatient detoxification and rehabilitative services in a Treatment Facility. Members must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by CareFirst.

C. The following Inpatient Health Care Practitioner benefits apply only if the Member is eligible for benefits under Section 7.3 for the day on which these services are rendered:

1. Health Care Practitioner visits during the Member's inpatient Treatment Facility stay, limited to one per day;

2. Intensive care that requires a Health Care Practitioner's attendance;

3. Consultation by another Health Care Practitioner when additional skilled care is required because of the complexity of the Member's condition.

4. Benefits are available for more than one inpatient visit per day if warranted by the complexity of the Member's condition. Benefits are not available for inpatient visits or consultations on any day on which Treatment Facility benefits have been denied.

Health Care Practitioner services provided to a hospitalized Member, including physician visits, charges for intensive care or consult services will be covered only if CareFirst determines that the Health Care Practitioner rendered services to the Member and that such services were Medically or Psychologically Necessary or required to diagnose or treat the Member's condition.

D. Utilization management approval is not required for methadone maintenance treatment.

7.4 Conditions and Limitations

Coverage of Mental Illness, Alcohol Abuse and/or Drug Abuse is subject to the limits described in the Schedule of Benefits, including limits on numbers of visits and days covered and, if applicable, limitations on the total benefits available for these services.

SECTION 8
MEDICAL DEVICES AND SUPPLIES

8.1 Definitions

Durable Medical Equipment means equipment which:

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.

Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry, including a disease for which the newborn babies are screened.

Low Protein Modified Food Product means a food product that is:

A. Specially formulated to have less than 1 gram of protein per serving; and

B. Intended to be used under the direction of a physician for the dietary treatment of an Inherited Metabolic Disease.

Low Protein Modified Food Product does not include a natural food that is naturally low in protein.

Medical Device means Durable Medical Equipment, Medical Food, Medical Supplies, Orthotic Device and Prosthetic Device.

Medical Food means a food that is:

A. Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and

B. Formulated to be consumed or administered under the direction of a physician.

Medical Supplies means items that:

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

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

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

D. Are consistent with the diagnosis;

E. Are appropriate for use in the home;

F. Cannot withstand repeated use; and

G. Are usually disposable in nature.

Orthotic Device means orthoses and braces which:

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

B. Are prescribed by a Health Care Provider;

C. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;

D. May be purely passive support or may make use of spring devices; and

E. Include devices necessary for post-operative healing.

Prosthetic Device means a device which:

A. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or

B. Is primarily intended to replace all or part of an organ or body part that was absent from birth; or

C. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and

D. Is prescribed by a Health Care Provider; and

E. Is removable and attached externally to the body.

8.2 Covered Services

A. Durable Medical Equipment
Rental, or, (at CareFirst's option), purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a Health Care Provider for therapeutic use for a Member's medical condition.

CareFirst's payment for rental will not exceed the total cost of purchase. CareFirst's payment is limited to the least expensive Medically Necessary Durable Medical Equipment, adequate to meet the Member's medical needs. CareFirst's payment for Durable Medical Equipment includes related charges for handling, delivery, mailing and shipping, and taxes.

B. Hair Prosthesis
Benefits are available for hair prosthesis when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer, subject to the limitations stated in the Schedule of Benefits.

C. Medical Foods and Low Protein Modified Food Products
Medical Foods and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases if the Medical Foods or Low Protein Modified Food Products are:

1. Prescribed as Medically Necessary for the therapeutic treatment of Inherited Metabolic Diseases; and;

2. Administered under the direction of a physician.

D. Medical Supplies

E. Nutritional Substances
Enteral and elemental nutrition when Medically Necessary as determined by CareFirst.

F. Orthotic Devices, Prosthetic Devices
Benefits include:

1. Supplies and accessories necessary for effective functioning of Covered Service;

2. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and

3. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

8.3 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.

8.4 Benefit Limits
Benefits will be limited to the lower cost of purchase or rental, taking into account the length of time the Member requires, or is reasonably expected to require the equipment, the durability of the equipment, etc. The purchase price or rental cost must be the 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 not determined by CareFirst to be Medically Necessary, CareFirst will pay an amount that does not exceed CareFirst's payment for the basic device (minus the Member Copayment) and the Member will be fully responsible for paying the remaining balance.

8.5 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 covered under this Evidence of Coverage.

SECTION 9
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 In-Network Providers located in the CareFirst service area. 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 Out-of-Network Non-Preferred Providers.

9.1 Utilization Management

Benefits are subject to review and approval under utilization management requirements established by CareFirst. Through utilization management, CareFirst will 1) review Member care and evaluate requests for approval of coverage in order to determine the Medical Necessity for the services; 2) review the appropriateness of the hospital or facility requested; and, 3) 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, second surgical opinion and/or preadmission testing requirements, concurrent review, discharge planning, and case management. Failure or refusal of the Member to comply with notice requirements and other utilization management authorization and approval procedures will result in the denial of, or a significant reduction, in 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 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.

9.2 Preferred Provider Responsibility

Preferred Providers are responsible for providing utilization management notices and obtaining necessary utilization management approvals on the Member's behalf for certain types of services. These are designated in the Schedule of Benefits. For these services, the Member will not be responsible for notification and approvals. However, the Member must advise the Preferred Provider that coverage exists under the Preferred Provider Plan. In addition, the Member must comply with utilization management requirements and determinations. Refusal to follow these requirements may result in coverage being reduced or excluded. In all other instances, it is the Member's responsibility to comply with the utilization management requirements.

9.3 Member Responsibility

If the Member is outside of the CareFirst service area, or care is rendered by a Non-Preferred Provider, the Member is responsible for all utilization management requirements. It is the Member's responsibility to assure 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. Prior authorization is not required for outpatient Mental Health and Substance Abuse Services rendered by a Non-Preferred Provider.

9.4 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 requirements of this section with family members and other responsible persons who could arrange for care on the Member's behalf in accordance with this section 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.

9.5 Services Subject to Utilization Management

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, except for outpatient Mental Health and Substance Abuse Services.

A. Hospital Inpatient Services

All hospitalizations (except for maternity 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. Maternity Admissions

   Prior authorization is not required for the 48 hour stay for an uncomplicated vaginal delivery, or the ninety-six (96) hour stay for uncomplicated cesarean section.

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.

C. Partial Hospitalization

Coverage of Partial Hospitalization is subject to prior authorization under the Mental Health Management Program of the need for treatment in a Qualified Partial Hospitalization Program and the duration of such treatment.

D. Transplants

Transplants and related services must be coordinated and authorized by CareFirst. Coverage for related medications may be available under either the Prescription Drug program or medical benefits.

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 facility 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 Services;
2. Skilled Nursing Facility Services;
3. Hospice Services;
4. Habilitative Services for Children;
5. Clinical trials;

CareFirst reserves the right to make changes to the categories of services that are subject to utilization management requirements or to the procedures Members and/or providers must follow. CareFirst will notify Subscribers of these changes at least thirty (30) days in advance.

9.6 Medicare as Primary

Prior authorization is not required for any Covered Services when Medicare is the primary insurer.

9.7 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.

9.8 Case Management

This is a feature of this health benefit plan for a Member with a chronic condition, serious illness, or complex health care needs. CareFirst will initiate and perform Case Management services, as deemed appropriate by CareFirst, which may include the following:

A. Assessment of individual/family needs related to the understanding of health status and physician treatment plans, self-care, compliance capability, and continuum of care;

B. Education of individual/family regarding disease, treatment compliance, and self-care techniques;

C. Help with organization of care, including arranging for needed services and supplies;

D. Assistance in arranging for a principal or primary care physician to deliver and coordinate the Member's care, and/or consultation with physician specialists; and,

E. Referral of Member to community resources.

9.9 Appealing a Utilization Management Decision

If the Member 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 Appeals Attachment to this Evidence of Coverage on how to appeal a utilization management decision.

SECTION 10
EXCLUSIONS AND LIMITATIONS

10.1 General Exclusions
Coverage is not provided for the following:

A. Any service, test, procedure, supply, or item which CareFirst determines not necessary for the prevention, diagnosis or treatment of the Member's illness, injury, or condition. Although a service may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.

B. Any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, in the judgment of CareFirst, is Experimental/Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for Clinical Trials.

C. The cost of services that are furnished without charge or are normally furnished without charge if a Member was not covered under the Evidence of Coverage or under any health insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the Member directly.

D. Any service, supply, or procedure that is not specifically listed in the Member's Evidence of Coverage as a covered benefit or that does not meet all other conditions and criteria for coverage as determined by CareFirst.

E. Services that are beyond the scope of the license of the provider performing the service.

F. Routine foot care, including services related to hygiene or any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, or partial removal of a nail without the removal of its matrix. However, benefits will be provided for these services if CareFirst determines that medical attention was needed because of a medical condition affecting the feet, such as diabetes and, that all other conditions for coverage have been met.

G. Any type of dental care (except treatment of accidental injuries, oral surgery, and cleft lip, cleft palate or both, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. Benefits for oral surgery are in Section 2.20 of the Description of Covered Services. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.

H. Cosmetic surgery (except benefits for Reconstructive Breast Surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by CareFirst.

I. Treatment rendered by a Health Care Provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.

J. Any prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment or unless the prescription drug is specifically identified as covered. Take-home prescriptions or medications, including self-administered injections

which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, even though they may be dispensed or administered in a physician or provider office or facility, unless the take-home prescription or medication is specifically identified as covered. Benefits for prescription drugs may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.

K. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except for benefits described in this Evidence of Coverage and diabetic supplies.

L. Food and formula consumed as a sole source or supplemental nutrition, except as listed as a Covered Service in the Description of Covered Services.

M. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.

N. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy and psychiatric treatment.

O. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac rehabilitation programs are covered as described in this Evidence of Coverage.

P. Medical and surgical treatment for obesity and weight reduction, including Morbid Obesity.

Q. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof. Benefits for vision may be available through a rider or amendment purchased by the Group and attached to the Evidence of Coverage.

R. Services solely based on a court order or as a condition of parole or probation, unless approved by CareFirst.

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

T. Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.

U. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a Health Care Practitioner.

V. Any service received at no charge to the Member in any federal hospital or facility, or through any federal, state, or local governmental agency or department, not including Medicaid. (This exclusion does not apply to care received in a Veteran's hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.)

W. Private Duty Nursing.

X. Non-medical, provider services, including, but not limited to:

1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges, or other administrative services provided by the Health Care Practitioner or the Health Care Practitioner's staff.

2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are available for Covered Services rendered to the Member by a Health Care Provider.

Y. Speech Therapy, Occupational Therapy, or Physical Therapy, unless CareFirst determines that the condition is subject to improvement. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.

Z. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law.

AA. Services or supplies 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, excluding no fault insurance.

BB. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under Section 2.13, Organ and Tissue Transplants of this Description of Covered Services), whether or not recommended by an Eligible Provider.

CC. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

DD. Contraceptive drugs or devices, unless specifically identified as covered in this Description of Covered Services, or in a rider or amendment to this Evidence of Coverage.

EE. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.

FF. Services, drugs, or supplies the Member receives without charge while in active military services.

GG. Habilitative Services delivered through early intervention and school services. Habilitative Services for a Member 21 years and older.

HH. Custodial Care.

II. Coverage does not include non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.

JJ. Services or supplies received before the effective date of the Member's coverage under this Evidence of Coverage.

KK. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.

LL. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

MM. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

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

10.3 Organ and Tissue Transplants
Benefits will not be provided for the following.

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts.

B. Any hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.

C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.

D. Services for a Member who is an organ donor when the recipient is not a Member.

E. Benefits will not be provided for donor search services.

F. Any service, supply, or device related to a transplant that is not listed as a benefit in the Description of Covered Services.

10.4 Inpatient Hospital Services
Coverage is not provided (or benefits are reduced, if applicable) for the following:

A. Private room, unless Medically Necessary and authorized or approved by CareFirst. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.

B. Non-medical items and convenience items, such as television and phone rentals, guest trays, and laundry charges.

C. Except for covered Emergency Services and maternity care, a hospital admission or any portion of a hospital admission (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private Duty Nursing.

10.5 Home Health Services
Coverage is not provided for:

A. Private Duty Nursing.

B. Custodial Care.

10.6 Hospice Services
Benefits will not be provided for the following:

A. Services, visits, medical equipment, or supplies not authorized by CareFirst.

B. Financial and legal counseling.

C. Any services for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.

D. Reimbursement for volunteer services.

E. Chemotherapy or radiation therapy, unless used for symptom control.

F. Services, visits, medical equipment or supplies that are not required to maintain the comfort and manage the pain of the terminally ill Member.

G. Custodial Care, domestic, or housekeeping services.

10.7 Medical Devices and Supplies

Benefits will not be provided for purchase, rental, or repair of the following:

A. Convenience items. Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member, (e.g., an exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench).

B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).

C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, (e.g. exercycle or other physical fitness equipment).

D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use the home (e.g. parallel bars).

E. Environmental control equipment. Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

F. Eyeglasses or contact lenses, except when used as a prosthetic lens replacement for aphakic patients as described in this Description of Covered Services including, dental prostheses or appliances.

G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts or special shoe accessories.

H. Medical equipment/supplies of an expendable nature, except as specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross Blue Shield (CareFirst)
840 First Street, NE
Washington, D.C. 20065
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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. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, Coinsurance or Copayment. Services that are not listed in the Description of Covered Services, or are listed in Exclusions and Limitations, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions of the Contract, its medical policies, and its operating procedures. When these policies and procedures are not followed, payments for benefits may be denied. Certain Utilization Management Requirements may apply. When these requirements are not met, payments may be denied or reduced.

SECTION 1 - 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. For purposes of determining the Deductible, any Type of Coverage that is not Individual is considered Family coverage. **The following amounts apply to the In-Network Deductible:** • 100% of the Allowed Benefit for covered In-Network services that are subject to the In-Network Deductible, as indicated in the benefit chart below.	The Individual Deductible is $500 per Benefit Period. The Family Deductible is $1,000 per Benefit Period. For purposes of determining the Deductible, any Type of Coverage that is not Individual is considered Family coverage. **The following amounts apply to the Out-of-Network Deductible:** • 100% of the Allowed Benefit for covered Out-of-Network services that are subject to the Out-of-Network Deductible, as indicated in the benefit chart below.

IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES

Individual Coverage: A Member who has Individual Coverage must meet the Individual Deductible.

Individual and Adult or Individual and Child Coverage: Two Members must satisfy their own Deductible by meeting 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 following amounts may not be used to satisfy the In-Network or Out-of-Network Deductibles:

- Amounts incurred for failure to comply with Utilization Management Program requirements, under the Out-of-Network benefits.
- The portion of any provider charge that is in excess of the Allowed Benefit.

The benefit chart below identifies whether a covered service is subject to a Deductible. Unless otherwise specifically stated, all benefits are subject to the Deductible. If a Deductible applies, the chart will also state whether a Deductible applies to In-Network benefits, Out-of-Network benefits, or both.

MAXIMUM COMBINED DEDUCTIBLE

By using a combination of In-Network and Out-of-Network services, this feature avoids having to meet two separate Deductibles. The total Deductible expenses (In-Network and/or Out-of-Network combined) are limited to the Out-of-Network Deductible amount. A Member can meet the Maximum Combined Deductible through any combination of In-Network and/or Out-of-Network Deductible expenses. If the Member meets the Maximum Combined Deductible, this automatically satisfies the In-Network and Out-of-Network Deductibles for that Benefit Period.

OUT-OF-POCKET LIMITS	
IN-NETWORK LIMIT	OUT-OF-NETWORK LIMIT
The Individual Out-of-Pocket Limit is $1,500 per Benefit Period. The Family Out-of-Pocket Limit is $3,000 per Benefit Period. For purposes of determining the Out-of-Pocket Limit, any Type of Coverage that is not Individual is considered Family coverage. **The following amounts apply to the In-Network Out-of-Pocket Limit:** • Coinsurance for covered In-Network Services • Copayments for covered In-Network Services • The In-Network Deductible • The Out-of-Network Deductible When the Member has reached the In-Network Out-of-Pocket Limit, no further Coinsurance or Copayments will be required in that Benefit Period for In-Network services.	The Individual Out-of-Pocket Limit is $3,000 per Benefit Period. The Family Out-of-Pocket Limit is $6,000 per Benefit Period. For purposes of determining the Out-of-Pocket Limit, any Type of Coverage that is not Individual is considered Family coverage. **The following amounts apply to the Out-of-Network Out-of-Pocket Limit:** • Coinsurance for covered Out-of-Network Services • The Out-of-Network Deductible • The In-Network Deductible When the Member has reached the Out-of-Network Out-of-Pocket Limit, no further Coinsurance or Copayments will be required in that Benefit Period for Out-of-Network services.

IN-NETWORK AND OUT-OF-NETWORK OUT-OF-POCKET LIMITS
Individual Coverage: A Member who has Individual Coverage must satisfy the Individual Out-of-Pocket Limit. **Individual and Adult or Individual and Child Coverage:** Two Members must satisfy the Individual Out-of-Pocket Limit to satisfy the Individual and Adult or Individual and Child Coverage Out-of-Pocket Limit. **Family Coverage**: Each Member can satisfy his/her own Individual Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit. In addition, eligible expenses of all covered family members can be combined to satisfy the Family Out-of-Pocket Limit. An individual family member cannot contribute more than the Individual Out-of-Pocket Limit toward meeting the Family Out-of-Pocket Limit. Once the Family Out-of-Pocket Limit has been met, this will satisfy the Out-of-Pocket Limit for all family members. **The following amounts may <u>not</u> be used to meet the In-Network or Out-of-Network Out-of-Pocket Limits:** • Coinsurance or Copayments, if any, for services covered under a rider or endorsement to the Evidence of Coverage, unless specifically provided in the rider or endorsement. • Amounts incurred for failure to comply with the utilization management program requirements. • The portion of any provider charges which is in excess of the Allowed Benefit.
MAXIMUM COMBINED OUT-OF-POCKET LIMIT
By using a combination of In-Network and Out-of-Network services, this feature avoids having to meet two separate Out-of-Pocket Limits. The total Out-of-Pocket expenses (In-Network and/or Out-of-Network combined) are limited to the Out-of-Network Out-of-Pocket Limit amount. The Member can meet the Maximum Combined Out-of-Pocket Limit through any combination of In-Network and/or Out-of-Network Out-of-Pocket Limit expenses. If the Member meets the Maximum Combined Out-of-Pocket Limit, this automatically satisfies the In-Network and Out-of-Network Out-of-Pocket Limit for that Benefit Period.
LIFETIME MAXIMUM
There is no Lifetime Maximum
UTILIZATION MANAGEMENT
Failure or refusal to comply with Utilization Management Requirements will result in: a 50% reduction in benefits for services associated with the Member's care or treatment. See Section 9 of the Description of Covered Services for services which require Utilization Management.

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
SECTION 2 - OUTPATIENT AND OFFICE SERVICES				
Office Visits		100% of the Allowed Benefit minus a Member Copayment of $20 per visit.	Out-of-Network, only	70% of the Allowed Benefit
Laboratory Tests and X-rays		90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
Other Diagnostic Procedures		90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit
Preventive Services				
Well-child care (Includes related lab tests and immunizations)	In accordance with the standards of the American Academy of Pediatrics	100% of the Allowed Benefit	No	100% of the Allowed Benefit
Routine GYN Exam		100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Adult Routine Physical Exam (Includes related services)	Age 18 and over	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Prostate Cancer Screening	In accordance with the most current American Cancer Society guidelines	100% of the Allowed Benefit	No	100% of the Allowed Benefit
Pap Smear	Annually and at intervals appropriate to the Member's age and health status, as determined by CareFirst	100% of the Allowed Benefit	No	70% of the Allowed Benefit
Mammography	One baseline mammogram and one screening mammogram annually thereafter	100% of the Allowed Benefit	No	100% of the Allowed Benefit
Colorectal Cancer Screening	In accordance with the most current American Cancer Society guidelines	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Diagnostic and Treatment Services				
Allergy Testing and Treatment		90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit
Allergy Shots		100% of the Allowed Benefit minus a Member Copayment of $5 per visit.	Out-of-Network, only	70% of the Allowed Benefit

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
Rehabilitation Services Rehabilitation Practitioners means eligible Physical Therapists, Speech Therapists, Occupational Therapists and Chiropractors	Limited to 30 visits per condition per Benefit Period	100% of the Allowed Benefit minus a Member Copayment of $20 per visit.	Out-of-Network, only	70% of the Allowed Benefit
Spinal Manipulation Services Rehabilitation Practitioners means eligible Physical Therapists, Speech Therapists, Occupational Therapists and Chiropractors	Limited to 20 visits per Benefit Period Benefits are limited to Members who are twelve (12) years of age or older	100% of the Allowed Benefit minus a Member Copayment of $20 per visit.	Out-of-Network, only	70% of the Allowed Benefit
Habilitative Services for Children	Limited to Members under the age of 21 Must be authorized in advance under utilization management requirements	100% of the Allowed Benefit minus a Member Copayment of $20 per visit.	Out-of-Network, only	70% of the Allowed Benefit
Therapeutic Treatment Services	As described in Attachment B, Description of Covered Services	90% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Outpatient Surgical Procedures	As described in Attachment B, Description of Covered Services	90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit
Anesthesia Services	Benefits apply when provided in connection with a covered procedure	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Outpatient Care				
Outpatient Hospital Facility Services	Routine/Screening Colonoscopy is not subject to the Deductible.	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Ambulatory Surgical Facility Services	Routine/Screening Colonoscopy is not subject to the Deductible.	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Professional Medical services provided at an outpatient hospital or ambulatory care facility	Routine/Screening Colonoscopy is not subject to the Deductible.	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
Professional Surgical services provided at an outpatient hospital or ambulatory care facility	Routine/Screening Colonoscopy is not subject to the Deductible. Must be authorized in advance under the utilization management program	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Cardiac Rehabilitation	Limited to 90 days per Benefit Period	100% of the Allowed Benefit minus a Member Copayment of $20 per visit.	Out-of-Network, only	70% of the Allowed Benefit
Other Covered Services	As described in Attachment B, Description of Covered Services	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Maternity and Related Services				
Maternity and Related Services	The Subscriber/Spouse and Dependent children are eligible for these benefits	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Emergency Services				
Emergency room services		100% of the Allowed Benefit minus a Member Copayment of $100 per visit.	No	100% of the Allowed Benefit minus a Member Copayment of $100 per visit.
Limited Service Immediate Care		100% of the Allowed Benefit minus a Member Copayment of $20 per visit.	Out-of-Network, only	70% of the Allowed Benefit
Ambulance Service		90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
Ambulance Services when the Member is Outside the United States	Limited to transportation to the nearest medically appropriate facility when the Member is outside the United States.	90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit
SECTION 3 - INPATIENT HOSPITAL SERVICES				
Inpatient Facility Services (medical or surgical condition, including maternity)	Must be authorized in advance under utilization management requirements	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Hospitalization for Rehabilitation	Hospitalization solely for rehabilitation limited to 90 days per Benefit Period.	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Inpatient Professional Medical Services	Must be authorized in advance under utilization management requirements	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Inpatient Professional Surgical Services	Covered only if hospitalization qualifies for coverage Must be authorized in advance under utilization management requirements	90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit
Anesthesia Services	Benefits apply when provided in connection with a covered procedure	90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
SECTION 4 - SKILLED NURSING FACILITY SERVICES				
Skilled Nursing Facility Services	Must be authorized in advance under utilization management requirements Limited to 60 days per Benefit Period	90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit
SECTION 5 - HOME HEALTH SERVICES				
Home Health Services	Must be authorized in advance under utilization management requirements Limited to 90 visits up to 4 hours per visit per "episode of care". A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for 60 consecutive days.	90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit
Postpartum Home Visits	As described in Attachment B of the Description of Covered Services	100% of the Allowed Benefit	No	100% of the Allowed Benefit

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
SECTION 6 - HOSPICE SERVICES				
Hospice Services	Must be authorized in advance under utilization management requirements Services limited to maximum 180 day Hospice Eligibility Period Inpatient care limited to 60 days per Hospice Eligibility Period Bereavement services covered only if provided within 90 days following death of the deceased	90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
SECTION 7 - MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES				
Outpatient Services				
Mental Health Outpatient Services		Per Benefit Period: Visits 1-40: 75% of the Allowed Benefit Visits in excess of 40: 60% of the Allowed Benefit	Out-of-Network, only	Per Benefit Period: Visits 1-40: 75% of the Allowed Benefit Visits in excess of 40: 60% of the Allowed Benefit
Substance Abuse Outpatient Services		Per Benefit Period: Visits 1-40: 75% of the Allowed Benefit Visits in excess of 40: 60% of the Allowed Benefit	Out-of-Network, only	Per Benefit Period: Visits 1-40: 75% of the Allowed Benefit Visits in excess of 40: 60% of the Allowed Benefit
Medication Management Office Visits		100% of the Allowed Benefit minus a Member Copayment of $20 per visit.	Out-of-Network, only	70% of the Allowed Benefit
Inpatient Services				
Inpatient Mental Health Facility Services	Must be authorized in advance under utilization management program Limited to 60 days per Benefit Period	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
Inpatient Substance Abuse Facility Services	Must be authorized in advance under utilization management program Limited to 60 days per Benefit Period	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Detoxification Services				
Detoxification	Limited to 12 visits (inpatient or outpatient) per Benefit Period	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
SECTION 8 - MEDICAL DEVICES AND SUPPLIES				
Medical Devices and Supplies	No annual dollar limit	90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit
Hair Prosthesis	Limited to maximum payment of $350 per Benefit Period Benefit does not apply to any annual maximums for Medical Devices and Supplies	100% of the Allowed Benefit	No	100% of the Allowed Benefit

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INTER-PLAN ARRANGEMENTS DISCLOSURE AMENDMENT

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

I. Out-of-Area Services

CareFirst has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of CareFirst service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. CareFirst explains below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by CareFirst to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when you receive covered healthcare services within the geographic area served by a Host Blue, CareFirst will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive covered healthcare services outside the CareFirst service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed charges for 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 your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your 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.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price CareFirst has used for your claim because they will not be applied after a claim has already been paid.

B. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, CareFirst will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

C. Nonparticipating Providers Outside CareFirst Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of CareFirst service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the covered healthcare services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, CareFirst may use other payment methods, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount CareFirst will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the covered healthcare services as set forth in this paragraph.

D. BlueCard Worldwide® Program

If you are outside the United States (hereinafter "BlueCard service area"), you may be able to take advantage of the BlueCard Worldwide® Program when accessing covered healthcare services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. **You must contact CareFirst to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services/Covered Services.

- **Submitting a BlueCard Worldwide Claim**

  When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from [us/Licensee Name], the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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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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 providers" or "contracted providers") with the local Blue Cross and/or Blue Shield Licensee in another geographic area, as well as non-participating providers in some instances.

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 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 provider), the Member is responsible for the participating 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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EMERGENCY ROOM HIV TESTING AMENDMENT

This Amendment is effective on March 21, 2009.

The evidence of coverage is amended as follows:

Benefits are available for the costs of a voluntary HIV test, performed during a Member's visit to a hospital emergency room, regardless of the reason for the hospital emergency room visit. Benefits for HIV testing performed in a hospital emergency room are not subject to any Deductible that may be stated in the Schedule 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 Evidence of Coverage unless specifically stated herein.

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MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES PARITY AMENDMENT REVISED

This amendment is effective on the effective date of the Evidence to which this amendment is attached.

I. Description of Covered Services, Section 7, Mental Health and Substance Abuse Services, is deleted and replaced as follows:

SECTION 7
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

7.1 Definitions. The following terms have the meanings described below:

Alcohol Abuse means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Drug Abuse means any pattern of pathological use of drugs that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Inpatient Services mean therapeutic services and supplies that are Medically Necessary and that are provided in a hospital or Non-Hospital Residential Facility to a patient according to an individualized treatment plan that requires the patient to be admitted.

Mental Illness means any mental disorder, mental illness, psychiatric illness, mental condition or psychiatric condition (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC)

Non-Hospital Residential Facility means a facility certified by the District of Columbia or by any jurisdiction in which it is located as a qualified non-hospital provider of treatment for Drug Abuse, Alcohol Abuse, Mental Illness, or any combination of these, in a residential setting. The term Non-Hospital Residential Facility includes any facility operated by the District, any state or territory, or the United States to provide these services in a residential setting. A Non-Hospital Residential Facility also must meet or exceed guidelines established for such a facility by us and as amended from time to time. It is not a facility licensed as a general or special hospital.

Outpatient Services mean therapeutic services and supplies that are Medically Necessary, and which are provided to a patient according to an individualized treatment plan that does not require the patient to be admitted to a hospital or Non-Hospital Residential Facility. The term Outpatient Services refers to services and supplies that may be provided in a hospital, a Non-Hospital Residential Facility, an Outpatient Treatment Facility or a Health Care Practitioner's office.

Outpatient Treatment Facility means a clinic, counseling center, or other similar location that is certified by the District of Columbia, or by any jurisdiction in which it is located as a qualified provider of outpatient services for the treatment of Drug Abuse, Alcohol Abuse, or Mental Illness. The term Outpatient Treatment Facility includes any facility operated by the District, any state or territory, or the United States to provide these services on an outpatient basis.

Partial Hospitalization means the provision of medically directed intensive or intermediate short-term treatment in a licensed or certified facility or program for treatment of Mental Illnesses, Drug Abuse and/or Alcohol Abuse.

Qualified Partial Hospitalization Program means a licensed or certified facility or program that provides medically directed intensive or intermediate short-term treatment for Mental Illness, Drug Abuse and/or Alcohol Abuse for a period of less than twenty-four (24) hours, but more than four (4) hours in a day.

Quarterway House means a residential facility for people who show the effects of Alcohol or Drug Abuse in which further use of alcohol or drugs is prevented and the pain caused by withdrawal is relieved.

Rehabilitation Home means a residential facility for people who show the effects of Alcohol Abuse or Drug Abuse and would be helped by a residential rehabilitation program.

Therapy Service means services rendered by an Eligible Provider to rehabilitate a Member who shows the effects of Alcohol Abuse and/or Drug Abuse including: psychotherapy; counseling; family therapy; drug therapy; behavior therapy; occupational therapy; and recreational therapy.

Treatment Facility means an Outpatient Treatment Facility, Quarterway House, Non-Hospital Residential Facility, Rehabilitation Home or hospital which operates a rehabilitation program for people who show the effects of Alcohol Abuse or Drug Abuse. For the purposes of the diagnosis, care and treatment of Mental Illness, the term Treatment Facility means a hospital, Non-Hospital Residential Facility or Outpatient Treatment Facility only. It must be licensed or certified by the proper authority in the area where the facility is located.

7.2 Outpatient Mental Health and Substance Abuse Services

To be eligible for benefits, a Health Care Practitioner must certify that the Member is suffering from a Mental Illness, Alcohol Abuse and/or Drug Abuse and prescribe Medically Necessary treatment (which may include referral to another Eligible Provider). Covered Services include:

A. Benefits are available for Outpatient Services (as described above) rendered by an Eligible Provider for the Medically Necessary treatment of Mental Illness, Alcohol Abuse and/or Drug Abuse.

B. Benefits are available for Partial Hospitalization (as described above) services rendered in a Qualified Partial Hospitalization Program.

C. Benefits are available for diagnosis and treatment for Alcohol Abuse and/or Drug Abuse, including outpatient detoxification and rehabilitative services in a covered alcohol or drug rehabilitation program or Qualified Partial Hospitalization Program.

D. Office visits for medication management in connection with Mental Illness, Alcohol Abuse and/or Drug Abuse will be covered on the same basis as other covered medical conditions.

7.3 Inpatient Services Mental Health and Substance Abuse Services

To be eligible for benefits, a Health Care Practitioner must certify that the Member is suffering from a Mental Illness, Alcohol Abuse and/or Drug Abuse and prescribe Medically Necessary treatment (which may include referral to another Eligible Provider). Coverage for Inpatient Services is subject to CareFirst certification of the need and continued appropriateness of such

services in accordance with CareFirst utilization management requirements. Covered Services include:

A. Benefits are available for Inpatient Services (including Therapy Services as described above) rendered by an Eligible Provider for the Medically Necessary treatment of Mental Illness, Alcohol Abuse and/or Drug Abuse.

B. Benefits are available for diagnosis and treatment for Alcohol Abuse and/or Drug Abuse, including inpatient detoxification and rehabilitative services in a Treatment Facility. Members must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by CareFirst.

C. The following Inpatient Health Care Practitioner benefits apply only if the Member is eligible for benefits under Section 7.3 for the day on which these services are rendered:

1. Health Care Practitioner visits during the Member's inpatient Treatment Facility stay, limited to one per day;

2. Intensive care that requires a Health Care Practitioner's attendance;

3. Consultation by another Health Care Practitioner when additional skilled care is required because of the complexity of the Member's condition.

4. Benefits are available for more than one inpatient visit per day if warranted by the complexity of the Member's condition. Benefits are not available for inpatient visits or consultations on any day on which Treatment Facility benefits have been denied.

Health Care Practitioner services provided to a hospitalized Member, including physician visits, charges for intensive care or consult services will be covered only if CareFirst determines that the Health Care Practitioner rendered services to the Member and that such services were Medically Necessary or required to diagnose or treat the Member's condition.

D. Utilization management approval is not required for methadone maintenance treatment.

7.4 Conditions and Limitations
Coverage of Mental Illness, Alcohol Abuse and/or Drug Abuse is subject to the limits described in the Schedule of Benefits.

II. Description of Covered Services, Section 9, Utilization Management, Subsection 9.5, Services Subject to Utilization Management, Provision C, Partial Hospitalization is deleted.

Description of Covered Services, Section 2, Utilization Management Requirements, Subsection 2.4.b, Inpatient Mental Health and Alcohol and Drug Abuse Services, and Subsection 2.4.c, Outpatient Mental Health and Substance Abuse Services are deleted.

III. Schedule of Benefits, Section 7, Mental Health and Substance Abuse Services, is deleted and replaced as follows:

Service	Limit on Benefits (In-Network and Out-of-Network Combined)	CareFirst Covers		
		In-Network	**Subject To Deductible**	**Out-Of - Network**
SECTION 7 – MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES				
Outpatient Mental Health and Substance Abuse Services				
Office Visits		100% of the Allowed Benefit minus Member Copayment of $20	Out-of-Network, only	70% of the Allowed Benefit
Outpatient Facility Services		100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Professional Services Provided at an Outpatient Facility		100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Medication Management		100% of the Allowed Benefit minus Member Copayment of $20	Out-of-Network, only	70% of the Allowed Benefit
Methadone Maintenance		100% of the Allowed Benefit	No	100% of the Allowed Benefit
Partial Hospitalization Facility Services		100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Partial Hospitalization Professional Services		100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Inpatient Mental Health and Substance Abuse Services				
Inpatient Mental Health and Substance Abuse Facility Services	Must be authorized in advance under utilization management program.	Benefits are available to the same extent as benefits provided for inpatient hospital services for treatment of other illnesses.	Out-of-Network, only	Benefits are available to the same extent as benefits provided for inpatient hospital services for treatment of other illnesses.
Inpatient Mental Health and Substance Abuse Professional Services	Must be authorized in advance under utilization management program.	Benefits are available to the same extent as benefits provided for inpatient medical or surgical care at an inpatient hospital for treatment of other illnesses.	Out-of-Network, only	Benefits are available to the same extent as benefits provided for inpatient medical or surgical care at an inpatient hospital for treatment of other illnesses.

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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EXEMPT PROVIDER AMENDMENT

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

The Evidence of Coverage is amended as follows:

Evidence of Coverage, Section 1, Definitions, is amended to delete the definition of Exempt Provider in its entirety.

Description of Covered Services, Section 1, General Provisions, Section 1.1A.2, Services Rendered by an Exempt Provider, is deleted in its entirety.

Description of Covered Services, Section 1, General Provisions, Section 1.1B, Out-of-Network Benefits, is deleted and replaced with:

> B. Out-of-Network Benefits
> Out-of-Network benefits apply when the Member obtains Covered Services from a provider who is not a Preferred Provider or in circumstances not addressed under Section 1.1A.3. When Out-of-Network benefits apply, the Member will receive reduced benefits for Covered Services. The benefit will be based on the appropriate Allowed Benefit. The level of benefits is provided under Out-of-Network Benefits in the Schedule of Benefits. The Member may be responsible for amounts in excess of the Allowed Benefit for these services, in addition to any applicable Deductibles, Coinsurance, and Copayments.

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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EXPANSION OF DEPENDENT COVERAGE AMENDMENT REVISED

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

TABLE OF CONTENTS

The Evidence of Coverage is amended as follows:

A. DEFINITION OF DEPENDENT CHILD

For the purposes of this amendment, a Dependent child is a child who is:

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

2. A child placed with the Subscriber or the Subscriber's covered Spouse for legal Adoption; or

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

All provisions of the Evidence of Coverage that define or describe the eligibility of a Dependent child who is described above for coverage under the Evidence of Coverage are revised to include a Dependent child described above who has not attained his or her 26th birthday notwithstanding the Dependent child's:

1. Financial dependency on an individual covered under the Evidence of Coverage;
2. Marital status;
3. Residency with an individual covered under the Evidence of Coverage;
4. Student status;
5. Employment;
6. Satisfaction of any combination of the above factors.

Nothing in this Amendment changes or amends the eligibility requirements for Primary Care Dependents that are stated in the Evidence of Coverage or in the Eligibility Schedule attached to the Evidence of Coverage.

B. ELIGIBILITY

All provisions of the Evidence of Coverage that state that the eligibility for coverage of a Dependent child described in Section A above is based on any factor other than the relationship between the Dependent child and an individual covered under the Evidence of Coverage are deleted. All requirements that the Dependent child described in Section A above, prior to his or her 26th birthday, be financially dependent on an individual covered under the Evidence of Coverage, that the Dependent child share a residence with an individual covered under the Evidence of Coverage that the Dependent child meet certain student status requirements, that the Dependent child be unmarried, or that the Dependent child not be employed, are deleted. Nothing in this amendment should be construed to amend any requirement related to the eligibility of a Dependent child over the age of 26 or to alter any requirement related to the eligibility of a dependent grandchild.

The eligibility requirements for Primary Care Dependents remain as stated in the Evidence of Coverage and in the Eligibility Schedule attached to the Evidence of Coverage.

C. TERMINATION

All provisions of the Evidence of Coverage that state that the coverage of a Dependent child described in Section A above will terminate when the Dependent child marries, ceases to be financially dependent on an individual covered under the Evidence of Coverage, ceases to share a residence with an individual covered under the Evidence of Coverage, ceases to be a full-time or part-time student, becomes employed full-time or part-time, or reaches the Dependent child's 25th birthday are deleted.

The Evidence of Coverage is amended to provide that the coverage of a Dependent child described in Section A above will terminate on the date the Dependent child reaches his or her 26th birthday or the age stated in the Eligibility Schedule, whichever is greater. The Limiting Age will not apply to a Dependent child described in Section A above, who at the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age, provided the incapacitated Dependent child is unmarried and dependent on an individual covered under the Evidence of Coverage. Coverage of the incapacitated Dependent child described in Section A above will continue for as long as the Dependent child remains incapable of self-support because of a mental or physical incapacity, unmarried, and dependent on an individual covered under the Evidence of Coverage.

The provisions relating to the Limiting Age and termination of coverage of Primary Care Dependents remain as stated in the Evidence of Coverage and in the Eligibility Schedule attached to the Evidence of Coverage.

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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PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

TABLE OF CONTENTS

The Evidence of Coverage is amended as follows:

A. Definitions

The following definitions have the following meaning in this amendment:

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

1. 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

2. 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)).

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

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Essential Health Benefits has the meaning found in section 1302 of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment;

prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with CareFirst to provide health care services to Members.

B. Lifetime Maximum

Any lifetime maximum on any Essential Health Benefit in the Evidence of Coverage is deleted.

The Evidence of Coverage is amended to provide that, if a Member's coverage under the Evidence of Coverage had terminated due to reaching a lifetime maximum, the Member may enroll during the first 30 days of a Benefit Period that begins on or after September 23, 2010, and coverage will begin on the first day of the Benefit Period that begins on or after September 23, 2010.

C. Annual Dollar Limits

Any annual dollar limit on Essential Health Benefits in the Evidence of Coverage is deleted. The annual dollar limitation on hair prostheses shall not be affected by this amendment.

D. Rescissions

Any provision of the Evidence of Coverage that describes the right of CareFirst to rescind or void the Evidence of Coverage is amended to permit CareFirst to rescind or void the coverage of a group or Member only if (1) the group or Member performs an act, practice, or omission that constitutes fraud; or (2) the group or Member makes an intentional misrepresentation of material fact.

Any provision of the Evidence of Coverage that provides for a notice of rescission of coverage is amended to provide 30-days advance written notice of any rescission of coverage.

E. Preventive Services

In addition to any other preventive benefits provided in the Evidence of Coverage, CareFirst shall cover the following preventive services and shall not impose any cost-sharing requirements, such as Deductibles or Copayment or Coinsurance amounts to any Member receiving any of the following benefits for services received from participating providers:

1. Evidenced-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, except that the current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

2. Immunizations 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 Member involved;

3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

CareFirst shall update new recommendations to the preventive services listed above pursuant to the schedule established by the Secretary of the United States Department of Health and Human Services.

F. Preexisting Condition Exclusion Periods for Members under the Age of 19

The following provisions of the Evidence of Coverage shall not apply to any Subscriber or Member who is under the age of 19:

1. Any provision that describes a Preexisting Condition or Preexisting Condition Exclusion Period;

2. Any provision that states that a Preexisting Condition Exclusion Period is applicable;

3. Any provision that states that benefits are contingent on an injury occurring or sickness first manifesting itself while the Subscriber or Member is covered under the Evidence of Coverage; and

4. Any provision of the Evidence of Coverage that describes possible denial or rejection of coverage due to an underwriting.

G. Emergency Services

Any provision of the Evidence of Coverage that provides benefits with respect to services in an emergency department of a hospital is amended to provide Emergency Services:

1. Without the need for any prior authorization determination, even if the Emergency Services are provided by a Non-Participating Provider;

2. Without regard to whether the health care provider furnishing the Emergency Services is a participating provider with respect to the services; and

3. If the Emergency Services are provided by a Non-Participating Provider, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from participating providers.

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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ADDITIONAL BENEFITS AMENDMENT

This amendment is effective on the effective date of the Evidence of Coverage to which it is attached.

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SECTION A- MAMMOGRAPHY SCREENING

The special limitations on "screening mammography" stated in the Preventive Services section of the Schedule of Benefits is deleted and replaces with the following:

There are no limitations on mammography screenings.

SECTION B- PULMONARY REHABILITATION SERVICES

The following is added as Section 2.12.G of the Description of Covered Services:

> Subject to any limitations stated in the Schedule of benefits, pulmonary rehabilitation services are provided to Members who have been diagnosed with a significant pulmonary disease, as defined by CareFirst, or who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all Medically Necessary pulmonary rehabilitation services, as determined by CareFirst. Services must be provided at a CareFirst approved place of service equipped and approved to provide pulmonary rehabilitation services.
>
> 1. Benefits will not be provided for Maintenance Programs.
>
> 2. Maintenance Program means activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of the treatment plan have been achieved or when no additional progress is apparent or expected to occur.
>
> 3. CareFirst pays only for covered services as described herein and the Schedule of Benefits. The Member pays for services, supplies or care that is not covered.
>
> 4. The Member pays any applicable Deductible, Copayment or Coinsurance.

Section 10.1.O of the Description of Covered Services, Exclusions and Limitations, is deleted and replaced with the following:

> Fees and charges relating to fitness programs, weight loss or weight control programs, physical or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education. Medically Necessary and approved pulmonary rehabilitation and cardiac rehabilitation services are covered as stated in the Description of Covered Services.

The following is added to the Schedule of Benefits:

SERVICE	LIMIT ON BENEFITS	CAREFIRST COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Outpatient Care				
Pulmonary Rehabilitation	Must be authorized in advance under the utilization management program. Preferred Providers will handle In-Network utilization management requirements on your behalf. Limited to 1 pulmonary rehabilitation program per lifetime. Benefits not provided for Maintenance Program.	CareFirst coverage will be the same as that provided for In-Network Outpatient Hospital Facility Services.	In-Network and Out-of-Network	CareFirst coverage will be the same as that provided for Out-of-Network Outpatient Hospital Facility Services.

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HEARING AID RIDER

This rider is issued by CareFirst to be attached to and become a 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 contains specific exclusions and limitations applicable to hearing aid benefits that are in addition to the exclusions contained in the Evidence of Coverage to which this rider is attached.

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A. DESCRIPTION OF COVERED SERVICES

Hearing Aids.

1. Benefits for a hearing aid are provided when the hearing aid is prescribed, fitted and dispensed by a licensed audiologist/supplier.

2. Benefits are also provided for related services, e.g., assessment, fitting, orientation, and conformity evaluation, related to the benefit for a hearing aid.

3. Limitations. Benefits are limited to Members under age nineteen (19).

B. SCHEDULE OF BENEFITS

Service	Limit on Benefits (In-Network and Out-of-Network combined)	CareFirst Covers		
		In-Network	**Subject to Deductible**	**Out-of-Network**
Hearing Aids	Limited to Members under age 19	90% of the Allowed Benefit	In-Network and Out-of Network Deductibles apply	70% of the Allowed Benefit
Hearing Aid Related Services	Limited to Members under age 19	90% of the Allowed Benefit	In-Network and Out-of Network Deductibles apply	70% of the Allowed Benefit

This rider is issued to be attached to the Evidence of Coverage.

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CONTINUATION OF COVERAGE FOR SURVIVING DEPENDENTS RIDER

The rider is issued by CareFirst to be attached to and become a part of the Evidence of Coverage issued by CareFirst. 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 to which this rider is attached.

Section 3.2, Death of a Subscriber of the Evidence of Coverage and the Upon Death of Subscriber provision of the Eligibility Schedule is deleted and replaced with the following:

3.2 In the event of the death of the Subscriber or retired Subscriber, coverage for any Dependent will continue until:

A. In the case of the Spouse of the deceased Subscriber or retired Subscriber, the Spouse remarries or dies.

B. In the case of a Dependent child of the deceased Subscriber or retired Subscriber, the Dependent child no longer meets the eligibility requirements as stated in the Eligibility Schedule.

In order for this continuation of coverage to apply, the Subscriber must have been employed by the Group for at least 5 year(s) immediately preceding his/her death or retirement and covered under the Group Contract to which this rider is attached at the time of death. Any Dependents seeking coverage under this rider must also have been covered under this Group Contract at the time of death of the Subscriber or retired Subscriber in order to be eligible to continue coverage under this provision.

This rider is subject to all of the terms and conditions of the Evidence of Coverage to which this rider is attached. This rider does not change any of those terms and conditions, except as specifically stated in this rider.

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OBESITY PREVENTION AND TREATMENT AMENDMENT

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which it is attached.

I. The Description of Covered Services is amended to add the following:

Prevention and Treatment of Obesity. Benefits will be provided for:

A. Well child care visit for obesity evaluation and management;

B. 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);

C. 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,

D. Office visits for the treatment of childhood obesity.

E. Limitations. Benefits for the treatment of obesity are limited to Members under age 19. Benefits for preventive care and screening for obesity are available to all Members.

F. Benefits for Prevention and Treatment of Obesity are available to the same extent as office visit benefits provided for preventive care services.

II. The Description of Covered Services is amended to add the following:

Professional Nutritional Counseling and Medical Nutritional Therapy.

A. Definitions

Professional Nutritional Counseling means individualized advice and guidance given to a Member 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.

Medical Nutrition Therapy, provided by a licensed dietitian-nutritionist, 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, take 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.

B. Covered Services. Benefits are available for Medically Necessary Professional Nutritional Counseling and Medical Nutrition Therapy as determined by CareFirst.

C. Benefits for Professional Nutritional Counseling and Medical Nutrition Therapy are available to the same extent as benefits provided for office visits for medical treatment.

III. Description of Covered Services, Section 10, Exclusions, Provision 10.1, General Exclusions, Item P, is deleted and replaced with the following:

P. Medical or surgical treatment for obesity, weight reduction, dietary control or commercial weight loss programs. This exclusion does not apply to:

1. Well child care visits 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;

4. Office visits for the treatment of childhood obesity; and

5. Professional Nutritional Counseling and Medical Nutrition Therapy as described in this amendment.

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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PATIENT-CENTERED MEDICAL HOME PROGRAM AMENDMENT

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which it is attached.

The Evidence of Coverage is amended as follows:

I. Evidence of Coverage Section 1, Definitions, is amended to add the following:

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 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.

Health Care Provider, as used in this amendment, means a physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services described in this amendment.

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 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 Patient-Centered Medical Home Program.

II. The Description of Covered Services, is amended to add the following:

Patient-Centered Medical Home Program. Benefits will be provided for:

A. Associated costs for coordination of care for the Qualifying Individual's medical conditions, including:

1. Liaison services between the Qualifying Individual and the Health Care Provider(s), nurse coordinator, and the Care Coordination Team.

2. Creation and supervision of the Care Plan, inclusive of an assessment of the

Qualifying Individual's medical needs.

3. Education of the Qualifying Individual/family regarding the Qualifying Individual's disease, treatment compliance and self-care techniques;

4. Assistance with coordination of care, including arranging consultations with Specialists, and obtaining other Medically Necessary supplies and services, including community resources.

B. 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 CareFirst Patient-Centered Medical Home Program.

C. Except for an Evidence of Coverage used in conjunction with a Health Savings Account (HSA), Patient-Centered Medical Home Program benefits are not subject to the Deductible. There is no Copayment or Coinsurance for benefits provided under this amendment.

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PRIOR AUTHORIZATION AMENDMENT

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which it is attached.

The Evidence of Coverage is amended as follows:

Transplants

Section 2.13 A. of the Description of Covered Services, Transplants, Covered Benefits, is deleted and replaced with the following:

A. Covered Benefits

Benefits for all Medically Necessary, non-Experimental/Investigational bone marrow, solid organ transplant, and other non-solid organ transplant procedures are covered, as determined by CareFirst. Prior authorization is required for all transplant services, except cornea and kidney transplants. Prior authorization will be granted only upon receipt of a written request from a physician.

Section 9.5.D. of the Description of Covered Services, Services Subject to Utilization Management, Transplants, is deleted and replaced with the following:

D. 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 may be available under either the Prescription Drug program or medical benefits.

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WOMEN'S PREVENTIVE HEALTH SERVICES AMENDMENT

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

I. Section 2.16 of the Description of Covered Services is deleted and replaced with the following:

2.16 Maternity and Related Services

A. Preventive Prenatal Services. Preventive prenatal services are provided for all female Members including:

1. Outpatient obstetrical care of an uncomplicated pregnancy, including pre-natal evaluation and management office visits, one post-partum office visit, and breastfeeding support supplies and consultation; and

2. Prenatal laboratory diagnostic tests and services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration.

3. These services, except for breastfeeding equipment, are covered to the same extent as other preventive services. Breastfeeding equipment is covered as stated in the Schedule of Benefits.

B. The following benefits are covered for all Members subject to the limitations stated in the Schedule of Benefits.

1. Outpatient obstetrical care and professional services for all prenatal and post-partum complications, including, but not limited to, prenatal and post-partum office visits not identified in Section 2.16A.1. above and ancillary services provided during those visits. Benefits include Medically Necessary laboratory diagnostic tests and services not identified in Section 2.16A.2. above including, but not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis.

2. Professional services rendered during a covered hospitalization for an uncomplicated delivery or for pregnancy-related complications or complications during delivery, including delivery via caesarian section, if the Member delivers during that episode of care, and all Ancillary Services provided during such an event.

3. Routine newborn care while the mother is hospitalized for covered maternity care provided the mother is a Member and eligible for maternity benefits. Coverage is limited to routine newborn visits (not to exceed two (2) visits) and male circumcision. To qualify for coverage of other services, the newborn must be a Member in his or her own right.

4. Inpatient postpartum treatment and postpartum home visits as described in Section 5.3 B, of this Description of Covered Services.

5. Dilation and curettage (D&C) or full term pregnancy for any female Member (including a Dependent) who became pregnant as the result of rape or incest.

II. The following is added to the Description of Covered Services:

Contraceptive Methods and Counseling.

A. Covered Benefits.

1. Contraceptive patient education and counseling for all Members with reproductive capacity.

2. Benefits will also be provided for all FDA approved contraceptive methods and sterilization procedures 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 for use by women as a contraceptive.

4. Contraceptive methods and counseling for female Members will be covered as stated in the Schedule of Benefits. Contraceptive methods and counseling for male Members will be covered to the same extent as non-preventive Outpatient and Office Services in the Schedule of Benefits.

5. Voluntary sterilization of adult male Members and surgical reversal of voluntary sterilization procedures for all adult Members. Benefits are available to the same extent as benefits provided for outpatient medical care, outpatient surgical care and diagnostic services.

B. Limitations.

Coverage is not provided for: (i) contraceptive devices and drugs that do not require administration by or under the direction of a physician; or (ii) contraceptive devices and drugs that can be self-administered by the patient or an average individual who does not have medical training. Benefits for covered self-administered contraceptive devices and drugs are provided under Prescription Drug Benefits Rider purchased by the Group and attached to this Evidence of Coverage.

III. The following is added to the Schedule of Benefits:

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
Contraceptive Methods and Counseling for Women	Female Members with reproductive capacity, only.	100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit
Breastfeeding Equipment		100% of the Allowed Benefit	Out-of-Network, only	70% of the Allowed Benefit

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INPATENT MATERNITY PRIOR AUTHORIZATION AMENDMENT

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which it is attached.

1. The Description of Covered Services is amended as follows:

   a. Section 9.5.A.1 of the Description of Covered Services is deleted and replaced with the following:

   1. Maternity Admissions
   There is no requirement to obtain prior authorization for inpatient maternity admissions.

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GENDER REASSIGNMENT AMENDMENT

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

The Evidence of Coverage is amended as follows:

The Description of Covered Services is amended to delete:

> Section 10.1 (M). Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.

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TOTAL CARE AND COST IMPROVEMENT, HEALTH PROMOTION, WELLNESS AND DISEASE MANAGEMENT PROGRAM 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 to add the following provisions:

I Definitions.

Biometric Screening means an onsite event during which Member screenings are provided for various measurements, such as: height, weight, BMI, waist circumference, blood pressure, LDL, HDL, total cholesterol, the total cholesterol to HDL ratio, triglycerides, and glucose.

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.

Disease Management Program means a coordinated, confidential program designed to manage a Member's chronic disease so that action can be taken to improve outcomes in the future.

Disease Management Coaching Session means an interactive coaching session provided to the Member with the Member's consent that furthers the Member's Disease Management Program.

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 ,high risk acute conditions or lifestyle behavior change.

Health Promotion and Wellness Program means a coordinated program designed to prevent disease, identify a Member's risk factors for disease or detect early stages of a Member's disease so that action can be taken to prevent poor outcomes in the future.

Primary Care Physician (PCP) means health care practitioners 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.

Weight Loss Services means CareFirst approved services available to clinically obese Members for the purpose of achieving measurable weight loss and sustainable weight maintenance, as part of the Health Promotion and Wellness Program.

Wellness Coaching Session means an interactive wellness coaching session provided to the Member with the Member's consent that furthers the Member's Health Promotion and Wellness Program.

II 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 II.A.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 II.A.1 or, pursuant to CareFirst initiation under Section II.A.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 II.D.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 II.E.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.

III Health Promotion and Wellness.

A. Health Assessments are available for all adult Members.

B. Benefits are available for Biometric Screening of Members, as defined above.

C. Lifestyle Coaching Session services are available as follows:

1. With the Member's consent, an initial discussion with a lifestyle coach to establish defined goal(s) for wellness coaching, and to determine the frequency of future coaching sessions in order to best meet the goal(s) established.

2. After the initial discussion, Coaching Sessions to track, support, and advance the Member's wellness/lifestyle goal(s).

D. Other Wellness Program benefits are available, and shall include tobacco-cessation, well-being challenges, and financial well-being improvement programs.

E. Weight Loss Services are available to clinically obese Members, as follows:

1. A clinically obese Member is a Member whose Body Mass Index (BMI) score is greater than thirty (30).

2. A dedicated, CareFirst approved coach is assigned to the Member to assist the Member in the development of healthy eating habits, physical activity habits, and to address the emotional, social, and environmental aspects shown to be important for sustained weight loss.

3. The Members receive one-on-one telephonic interventions with the coach and online educational resources, robust food, exercise trackers, recipes, peer-to-peer communication, and group community features for complete social support and accountability.

IV Disease Management.

A. Disease Management services, which may include a Disease Management Program to help the Member understand his/her disease and health status and physician treatment plans, individual and family education regarding the disease, treatment compliance and self-care techniques, and help to organize care for the disease, including arranging for needed services and supplies.

B. Disease Management Coaching Session services are available as follows:

1. With the Member's consent, an initial discussion with a coach to establish defined goal(s) for disease management coaching, and to determine the frequency of future coaching sessions in order to best meet the established goal(s) and manage the disease.

2. After the initial discussion, Disease Management Coaching Sessions to track, support, and advance the Member's disease management goal(s).

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2014 CONTROLLED CLINICAL TRIALS MANDATE AMENDMENT

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which it is attached.

The Evidence of Coverage is amended as follows:

Controlled Clinical Trials

A. The following definitions are added to Section 1, Definitions, of the Evidence of Coverage

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.

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.

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.

B. Section 2.15 of the Description of Covered Services is deleted and replaced with the following:

2.15 Controlled Clinical Trials.

A. Benefits will be provided to a Member in a Controlled Clinical Trial if the Member's participation in the Controlled Clinical Trial is the result of:

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-Experimental/Investigational treatment alternative;

5. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Experimental/Investigational alternative; and,

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.

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OPEN ENROLLMENT AMENDMENT

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which it is attached.

The Evidence of Coverage is amended as follows:

I. Definitions. In Section 1, Definitions, of the Evidence of Coverage, the following definition is added:

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.

II. Open Enrollment Opportunities. Section 2.6 of the Evidence of Coverage is deleted and replaced with the following:

2.6 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 Subscriber. If a Subscriber is a new employee or a newly eligible employee of the Group, new employee or a newly eligible employee may enroll as a Subscriber within sixty (60) days after a new employee or a newly eligible employee first becomes eligible. The eligibility requirements for Newly Eligible Subscribers in the Group are stated in the Eligibility Schedule.

C. Coverage of a Newborn Dependent Child, Newly Adopted Dependent Child or Newly Eligible Dependent Child, a Minor Dependent Child for whom Guardianship is granted by Court or Testamentary Appointment or Grandchild for whom the Member has legal custody. Enrollment requirements for an eligible Newborn Dependent Child, Newly Adopted Dependent Child or Newly Eligible Dependent Child, a Minor Dependent Child for whom Guardianship is granted by Court or Testamentary Appointment or Grandchild for whom the Member has legal custody depend on the Type of Coverage that is in effect on the date of the child's First Eligibility Date, as defined below.

D. "First Eligibility Date" means:

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

2. For a newly adopted Dependent Child, the earlier of:

a. A judicial decree of adoption; or

b. Placement of the Dependent Child in the Subscriber's home as the legally recognized proposed adoptive parent.

3. For a Dependent Child for whom a Member has been granted legal custody, the date of the court decree or the date the court decree becomes effective, whichever is later.

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

E. Family Coverage. If a Subscriber already has Family Coverage on the Dependent Child's First Eligibility Date, a newborn Dependent Child, newly adopted Dependent Child, newly eligible Dependent Child or a minor Dependent Child for whom guardianship is granted by court or testamentary appointment will be covered automatically as of the child's First Eligibility Date. Any Type of Coverage listed in the Eligibility Schedule that is not Individual, Individual and Adult or Individual and Child is considered Family coverage.

F. Individual Coverage. If a Subscriber has Individual Coverage on 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 Dependent Child's First Eligibility Date. If a Subscriber wishes to continue coverage beyond this 31 day period, the Subscriber must enroll the child within thirty-one (31) days following the Dependent Child's First Eligibility Date. Premium changes resulting from the addition of the Dependent Child will be effective as of the child's First Eligibility Date

G. Individual and Adult or Individual and Child Coverage. This provision applies only to Groups that offer an Individual and Adult or Individual and Child category of coverage. If a Subscriber has Individual and Adult or Individual and Child coverage on the Dependent Child's First Eligibility Date, the Dependent Child will be covered automatically as of the Dependent Child's First Eligibility Date. However, if addition of the Dependent Child results in a change in the Subscriber's Type of Coverage (e.g., from Individual and Adult or Individual and Child coverage to Family coverage), the Dependent Child's automatic coverage will end on the thirty-first (31st) day following the child's First Eligibility Date. If the Subscriber wishes to continue coverage beyond this thirty-one (31) day period, he or she must enroll the Dependent Child within thirty-one (31) days following the First Eligibility Date. The change in Type of Coverage and corresponding premium for the Subscriber's new Type of Coverage will be made effective as of the child's First Eligibility Date.

H. Coverage of Children under Court or Administrative Order**.** If the Subscriber (or another employee who is otherwise eligible for coverage under this Group Contract) is required under a court or administrative order to provide coverage under this Group Contract for the Subscriber's Dependent child (or Dependent children), the Subscriber (or employee) may enroll the eligible minor Dependent child (or Dependent children) included in the order and, if required, the Subscriber, at any time following the date on which the order was signed by a competent court or administrative agency without being subject to any enrollment period restrictions. If the Group is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Group will determine whether an order received by the Group with respect to employees of the Group and their children is a Qualified Medical Support Order (as that term is

defined under ERISA) or Medical Child Support Order and whether such children are eligible for coverage under that order.

I. New Family Member (Other than a Newborn Child or Newly Adopted Child, Newly Eligible Grandchild or a Minor for whom Guardianship Has Been Granted by Court or Testamentary Appointment). If a person is already a Subscriber, the Subscriber may enroll new family members, such as a new Spouse or stepchild, and/or change the Type of Coverage to include the new family member within thirty-one (31) days following the date the new family member first becomes eligible.

J. 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 as stated in this section, he or she may only enroll during a special enrollment period defined in Section 2.7 of this Certificate of Coverage.

III. Removal of Preexisting Condition Exclusion Periods. Sections 2.8 and 2.9 the Evidence of Coverage are deleted.

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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COORDINATION OF BENEFITS AMENDMENT

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

The Evidence of Coverage is amended as follows:

Section 5.2 of the Evidence of Coverage is deleted and replaced with the following:

5.2 Medicare Eligibility.
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 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.

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SPINAL MANIPULATION AMENDMENT

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

The Evidence of Coverage is amended as follows:

1. In Section 2.6 Spinal Manipulation, of the Description of Covered Services, the following is deleted from Section A.

   Spinal Manipulation services are limited to Members who are twelve (12) years of age or older.

2. In the Schedule of Benefits, the following is deleted from the Limit on Benefits column in the Schedule of Benefits, Spinal Manipulation Services service break:

   Benefits are limited to Members who are twelve (12) years of age or older.

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2017 AMENDMENT

This amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

TABLE OF CONTENTS

The Evidence of Coverage is amended as follows:

SECTION A - DEFINITIONS

1. The definition of "Allowed Benefit" in Section 1 of the Evidence of Coverage is deleted and replaced with the following:

Allowed Benefit means:

A. For a Preferred Provider, the Allowed Benefit for a Covered Service is the amount agreed upon between CareFirst and the Preferred Provider which, in some cases, will be a rate set by a regulatory agency. The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance amounts, for which the Member is responsible.

B. For a Non-Preferred Provider that is a health care practitioner, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the provider at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the practitioner's actual charge. The provider may bill the Member directly for such amounts. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Provider charge.

C. For a Non-Preferred Provider that is a health care facility, the Allowed Benefit for a Covered Service is based upon either the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the facility, at the discretion of CareFirst. Benefit payments to Department of Defense and Veteran Affairs providers

will be made directly to the provider. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the provider's actual charge. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Facility.

In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment, or Coinsurance amounts, for which the Member is responsible.

D. For a Covered Service rendered by a Non-Preferred Provider of ambulance services, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the Non-Preferred Provider of ambulance services, at the discretion of CareFirst. When benefits are paid to the Member, it is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Provider of ambulance services. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the provider's actual charge. The provider may bill the Member directly for such amounts.

For Emergency Services provided by a Non-Preferred Provider, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge, or the amount that would be paid to a Preferred Provider for the Covered Service. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the practitioner's actual charge. The provider may bill the Member directly for such amounts.

2. The definition of "Prescription Drug" in Section 1 of the Evidence of Coverage is deleted and replaced with the following:

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.

E. Prescription Drugs do not include:

1. Compounded bulk powders that contain ingredients that:

a) Do not have FDA approval for the route of administration being compounded, or

b) Have no clinical evidence demonstrating safety and efficacy, or

c) Do not require a prescription to be dispensed.

2. Compounded drugs that are available as a similar commercially available Prescription Drug unless:

a) There is no commercially available bio-equivalent Prescription Drug; or

b) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

3. All references to "Prior Authorization List" in the Evidence of Coverage are replaced with "Prescription Guidelines".

The following definition is added to Section 1, Definitions:

Prescription Guidelines 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 and the quantity limits CareFirst has placed on certain drugs. A copy of the Prescription Guidelines is available to the Member upon request.

4. All references to "Preferred Preventive Drug" in the Evidence of Coverage are replaced with "Preventive Drug".

The following definition of "Preventive Drug" is added to Section 1, Definitions:

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 Preventive Drug List.

5. All references to "Preferred Preventive Drug List" in the Evidence of Coverage are replaced with "Preventive Drug List".

The following definition of "Preventive Drug List" is added to Section 1, Definitions:

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 Preventive Drug List is available to the Member upon request.

SECTION B – ELIGIBILITY OF DEPENDENT CHILDREN

All provisions of the Evidence of Coverage that define or describe Eligibility of Dependent Children are revised as follows:

A Dependent Child means an individual who:

A. Is:

1. The natural child, stepchild, adopted child, or foster child of the Subscriber;

2. A child 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;

4. An unmarried grandchild, niece or nephew, who meets the requirements for coverage as the Subscriber's Primary Care Dependent as stated below:

a) The child must be the Subscriber's unmarried grandchild, niece, or nephew;

b) The child is under the Subscriber's Primary Care. Primary Care means the Subscriber provides food, clothing and shelter for the child on a regular and continuous basis during the time District of Columbia public schools are in regular session; and,

c) If the child's legal guardian is someone other than the Subscriber, the child's legal guardian is not covered under any other health insurance policy.

The Subscriber must provide CareFirst with proof upon application that the child meets the requirements for coverage as a Primary Care Dependent, including proof of the child's relationship and primary dependency on the Subscriber and certification that the child's legal guardian does not have other coverage. CareFirst reserves the right to verify whether the child is and continues to qualify as a Primary Care Dependent, and

5. A child who becomes a Dependent of the Subscriber through a child support order or other court order.

SECTION C - PROOF OF LOSS

General Provisions, Proof of Loss, of the Evidence of Coverage is deleted and replaced with the following:

Proof of Loss. For Covered Services provided by Non-Preferred Providers, Members must furnish written proof of loss, or have the provider submit proof of loss, to CareFirst within one (1) year 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 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.

SECTION D- CONVERSION PRIVILEGE

The Conversion Privilege section of the Evidence of Coverage is deleted in its entirety.

SECTION E - MEMBER PRIVACY

General Provisions, Member Privacy, of the Evidence of Coverage deleted and replaced with the following:

Member Privacy. 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 unauthorized third parties any personally identifiable financial or medical information without the prior written authorization of the Member or parent/guardian of the Member or as otherwise permitted by law. Personal

information, including email addresses and phone numbers, may be used and shared with other businesses who work with CareFirst to administer and/or provide benefits under this plan. Personal information may also be used to notify enrollees about treatment options, health-related services, and/or coverage options. Enrollees may contact CareFirst to change the information used to communicate with them.

SECTION F - CREDIT MONITORING

The following is added to the General Provisions section of the Evidence of Coverage:

Credit Monitoring. CareFirst is offering credit monitoring to the Subscriber and eligible Dependents at no additional charge through services administered by Experian. Credit monitoring is available on an opt-in basis for all eligible Members during the effective Benefit Period of their CareFirst health insurance policy. Eligible Members may enroll by calling the number on the back of the Member's ID card or visiting www.carefirst.com.

SECTION G – EXCLUSIONS AND LIMITATIONS

Section 10.1 LL of the Description of Covered Services is deleted and replaced with:

LL. Services required solely for administrative purposes, including but not limited to employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

SECTION H – PRESCRIPTION DRUGS

The following is added to the Prescription Drug Benefits Rider:

A Member may obtain up to a twelve (12) month supply of contraceptives at one time.

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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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SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("guaranty Association").

The purpose of the Guaranty Association is to assure that policy or contract holders of certain types of insurance policies and contracts are covered up to the statutory levels of protection of contractual benefits in the unlikely event that a member insurer is unable to meet its financial obligations and found by a court of law to be insolvent. When a member company is found by a court to be insolvent, the guaranty Association will assess its other member insurers to provide benefits on any outstanding covered claims of persons who reside in the District of Columbia. However, this additional protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep them in-force, with no change in contractual rights or benefits.

Coverage

The District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association"), established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code §31-5401 et seq.), provides insolvency protection for certain types of insurance policies and contracts. NOTE: Certain policies and contracts may not be covered or fully covered.

The insolvency protections provided by the Guaranty Association are generally conditioned on an individual being a resident of the District and are the insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are insured under a under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of the District insureds are also covered under the Act, even if they live in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable for which the insurer would have been liable if it were not an impaired or insolvent insurer; or

- With respect to any one life, regardless of the number of policies, contracts, or certificates:

    - ► $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
    - ► $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
    - ► $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
    - ► $300,000 for long-term insurance care benefits;
    - ► $300,000 for disability insurance;
    - ► $500,000 for basic hospital, medical, and surgical insurance, or major medical insurance;
    - ► $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long-term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 with respect to any one life ($500,000 in the event of basic hospital, medical, and surgical, and major medical claims).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner of regardless of the number of policies owned.

Exclusions Examples
Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to the District of Columbia Department of Insurance, Securities and Banking (DISB) will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

District of Columbia
Department of Insurance, Securities and Banking
810 First Street, N.E., Suite 701
Washington, DC 20002
(202) 727-8000

District of Columbia
Life and Health Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and statutory coverage protections. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to later any right established in any policy or contract, or under the Act.

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

An independent licensee of the Blue Cross and Blue Shield Association

VISION CARE RIDER

This rider is issued by CareFirst to be attached to and become a 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 contains certain terms that have a specific meaning as to Vision Care benefits. These terms are capitalized and are defined in Section A. below, or in the Evidence of Coverage to which it is attached.

This rider contains specific exclusions and limitations applicable to Vision Care benefits that are in addition to the exclusions contained in the Evidence of Coverage to which this rider is attached.

Limited Benefit, Please Read Carefully

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A. GENERAL PROVISIONS

1. Benefits for routine Vision Care are limited to the services listed in this rider. Benefits under this rider are administered by CareFirst's Vision Care Designee.

2. The Member's responsibility for covered Vision Care is stated in Section D, How It Is Covered. In addition, the Member will be responsible for services, supplies or care which are not covered. Services, supplies or care that are not listed as Vision Care benefits or are listed as an exclusion are not covered services under this rider.

3. Timely Filing.

   All claims submitted to the Vision Care Designee must be submitted within twelve (12) months after the date the covered service is received. Failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the Member, not later than one (1) year from the time proof is otherwise required.

4. There are no conversion privileges under this rider.

B. 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:

Allowed Benefit means:

1. For a Contracting Provider, the Allowed Benefit for a covered service is the lesser of:

   a. The actual charge; or

   b. The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date that the service is rendered.

   The benefit payment is made directly to a Contracting Provider. When a Member receives a vision examination from a Contracting Provider, the benefit payment is accepted as payment in full, except for any applicable copayment. The Contracting Provider may collect any applicable copayment.

2. For a Non-Contracting Provider, the Allowed Benefit for a covered service will be determined in the same manner as the Allowed Benefit to a Contracting Provider.

   Benefit may be paid to the Member or to the Non-Contracting Provider at the discretion of the Vision Care Designee. The Member is responsible for the cost difference between the Vision Care Designee's payment and the Non-Contracting Provider's actual charge. The Non-Contracting Provider may bill the Member directly for such amounts. It is the Member's responsibility to apply any Vision Care Designee payments to the claim from the Non-Contracting Provider.

Benefit Period means the period of time during which covered Vision Care benefits are eligible for payment. The Benefit Period is on a Calendar year basis.

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

Non-Contracting Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Vision Care is 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 Vision Care. A Non-Contracting Provider under this rider may or may not have contracted with CareFirst. The Member should contact the Vision Care Designee for the current list of Contracting Providers.

Vision Care means those services for which benefits are provided under this rider.

Vision Care Designee means the entity with which CareFirst has contracted to administer Vision Care. CareFirst's Vision Care Designee is Davis Vision, Inc. Davis Vision, Inc. is an independent company and administers the Vision Care benefits on behalf of CareFirst BlueCross BlueShield.

C. WHAT IS COVERED

1. Vision Examination

   a. One vision examination per Benefit Period. A vision examination may include, but is not limited to:

      i. Case history;

      ii. External examination of the eye and adnexa;

      iii. Ophthalmoscopic examination;

      iv. Determination of refractive status;

      v. Binocular balance testing;

      vi. Tonometry test for glaucoma;

      vii. Gross visual field testing;

      viii. Color vision testing;

      ix. Summary finding; and,

      x. Recommendation, including prescription of corrective lenses.

D. HOW IT IS COVERED

1. When the Member receives a vision examination from a Contracting Provider, the benefit payment is accepted as payment in full, except for any applicable Copayment.

2. When the Member receives Vision Care from a Non-Contracting Provider, the Member is responsible for the cost difference between the Vision Care Designee's payment and the Non-Contracting Provider's actual charge. The Vision Care Designee's payment will be the lesser of the Non-Contracting Provider's actual charge and the Out-of-Network payment amount listed in the Schedule of Benefits below.

3. Unless otherwise stated above, all Vision Care benefits are limited to one service per Benefit Period.

E. SCHEDULE OF BENEFITS

Covered Service	Vision Care Designee Payment	
	In-Network	Out-Of-Network
Vision Examination	100% of the Allowed Benefit after a Member copayment of $10 when Member receives covered services from a Contracting Provider.	$33

F. EXCLUSIONS

The following services are excluded from coverage:

1. Diagnostic services, except as listed in WHAT IS COVERED.

2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage to which this rider is attached.

3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage to which this rider is attached.

4. Services or supplies not specifically approved by the Vision Care Designee where required in WHAT IS COVERED.

5. Orthoptics, vision training and low vision aids.

6. Glasses, sunglasses or contact lenses.

7. Except as otherwise provided in this rider, Vision Care services for cosmetic use.

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

Group Hospitalization and Medical Services, Inc.
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An independent licensee of the Blue Cross and Blue Shield Association

PRESCRIPTION DRUG BENEFITS RIDER

This rider is issued by CareFirst to be attached to and become a 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 contains specific exclusions and limitations applicable to Prescription Drug benefits that are in addition to the exclusions contained in the Evidence of Coverage to which this rider is attached.

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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:

Prescription Drug Allowed Benefit, as used in this rider, means:

The Prescription Drug Allowed Benefit for covered Prescription Drugs is the lesser of:

1. The Pharmacy's actual charge; or

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

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

If the Member purchases a covered Prescription Drug from a non-Contracting Pharmacy, 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 in the amount of the Allowed Benefit, minus any applicable Deductible, or Copayment or Coinsurance. Members may be responsible for balances above the Prescription Drug Allowed Benefit.

Benefit Period, as used in this rider, means the period of time during which covered Prescription Drug benefits are eligible for payment. The Benefit Period is on a calendar year basis.

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.

Coinsurance, as used in this rider, means the percentage of the Prescription Drug Allowed Benefit allocated between CareFirst and the Member, whereby CareFirst and the Member share in the payment for covered Prescription Drugs.

Contracting Pharmacy, as used in this rider, means the separate independent Pharmacist or Pharmacy that has contracted with CareFirst or its designee to provide Prescription Drugs in accordance with the terms of this rider.

Copayment (Copay), as used in this rider, means a fixed dollar amount that a Member must pay for certain covered Prescription Drugs.

Diabetic Supplies means all Medically Necessary and appropriate supplies prescribed by a health care provider for the treatment of diabetes.

Exclusive Specialty Pharmacy Network means a pharmacy network that is limited to certain specialty Pharmacies that have been designated as "Exclusive" by CareFirst. Members may contact CareFirst for a list of Pharmacies in the Exclusive Specialty Pharmacy Network.

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

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

Over-the-Counter, as used in this rider, means medications and supplies that may be purchased without a prescription.

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.

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

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 Members upon request.

Preferred Preventive Drug means a Prescription Drug, including an 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 a Prescription Drug, including an Over-the-Counter medication or supply, dispensed under a written prescription by a health care provider, that is included on the list issued by CareFirst of the items 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 Members upon request.

Prescription Drug, as used in this rider, means: (i) a drug, biological or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;" (ii) 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; (iii) an Over-the-Counter medication or supply included on the Preferred Preventive Drug List; and (iv) any Diabetic Supplies

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 Members upon request.

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).

B. PRESCRIPTION DRUG BENEFITS

1. Except as provided in Section C below, benefits will be provided for a Prescription Drug dispensed by a Pharmacist for self-administered-use on an outpatient basis for the treatment of a condition for which benefits are provided under the terms of the Evidence of Coverage or an attached rider.

2. CareFirst or its designee reserves the right to substitute a Generic Drug for any Brand Name Drug unless otherwise indicated on the prescription order.

3. Members may obtain up to a thirty-four (34) day supply of a non-Maintenance Drug from a Pharmacist or through the mail order program. Members may also obtain up to a ninety (90) day supply of a Maintenance Drug from a Pharmacist or through the mail order program.

4. A Member may select a Prescription Drug that is not included on the Preferred Drug List. In addition to the non-Preferred Brand Name Drug Copayment or Coinsurance, an additional penalty will apply if the non-Preferred Brand Name Drug is a Brand Name Drug that has a Generic Drug equivalent. If a Member selects a non-Preferred Brand Name Drug when a Generic Drug is available, the Member will pay the non-Preferred Brand Name Drug Copayment or Coinsurance plus the difference between the price of the non-Preferred Brand Name Drug and the Generic Drug up to the cost of the prescription. This Generic Drug penalty will not apply to the Member's Deductible or Out-of-Pocket Maximum.

5. If a provider prescribes, and the Member selects, a 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.

6. Preferred Providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Prescription Drug on the Prior Authorization List. When the Member obtains care from a Non-Preferred Provider, the Member will be responsible to obtain prior authorization for any Prescription Drug on the Prior Authorization List. A list of Prescription Drugs on the Prior Authorization List is

available to the Member upon request. Where the Member is responsible to obtain prior authorization for a Prescription Drug on the Prior Authorization List and fails to do so, benefits will be reduced in the manner set forth in the Schedule of benefits attached to the Evidence of Coverage.

7. **Timely Filing**: All claims submitted to CareFirst or its designee for Prescription Drugs purchased at a non-Contracting Pharmacy must be submitted within twelve (12) months after the date the Prescription Drug was dispensed. CareFirst or its designee will only consider claims beyond the twelve (12) month filing period if the Member became legally incapacitated prior to the end of the filing period.

8. Benefits include:
   a. Any contraceptive drug or device that is approved by the FDA for use by a female member as a contraceptive and is obtained under a prescription written by an authorized prescriber , including contraceptive drugs and devices on the Preferred Preventive Drug List. Coverage for procedures for insertion or removal and any Medically Necessary examinations associated with the use of such contraceptive drugs or devices shall be provided under the medical benefits outlined in the Evidence of Coverage to which this rider is attached.

   b. Human growth hormones.

   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.

   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: lancets, alcohol wipes, test strips (blood and urine), syringes and needles.

   h. Infertility drugs or agents except for use in connection with infertility services or treatments excluded from coverage under the Evidence of Coverage.

   i. Oral chemotherapy drugs.

C. BENEFITS FOR SPECIALTY DRUGS

Benefits will be provided for Specialty Drugs only when obtained from a Pharmacy that is part of the Exclusive Specialty Pharmacy Network.

D. 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. Members will be responsible for the Copayment or Coinsurance as outlined in Section D, Copayments and Coinsurance, below.

E. COPAYMENTS AND COINSURANCE

Subject to the limitations and conditions stated in the limitations column and in the numbered paragraphs below, Prescription Drugs and Specialty Drugs are subject to the following Copayment or Coinsurance.

SERVICE	LIMITATIONS	MEMBER PAYS
Prescription Drugs – Non-Maintenance Drugs	Limited to a 34-day supply of Prescription Drugs that are not Specialty Drugs. This provision does not apply to covered injectable medications.	**Preferred Preventive Drugs:** No Copayment or Coinsurance **Generic Drugs:** $10 Copayment per prescription or refill **Preferred Brand Name Drugs:** $30 Copayment per prescription or refill **Non-Preferred Brand Name Drugs:** $55 Copayment per prescription or refill.
Prescription Drugs - Maintenance Drugs	Limited to a 90-day supply of Prescription Drugs that are not Specialty Drugs. This provision does not apply to covered injectable medications.	**Preferred Preventive Drugs:** No Copayment or Coinsurance **Generic Drugs:** $20 Copayment per prescription or refill **Preferred Brand Name Drugs:** $60 Copayment per prescription or refill **Non-Preferred Brand Name Drugs:** $110 Copayment per prescription or refill.
Prescription Drugs – Covered Injectable Medications	This provision does not apply to Specialty Drugs.	**Non-Maintenance Drug:** 50% of the Prescription Drug Allowed Benefit per prescription or refill. The Member's minimum payment is $10 per prescription or refill. The Member's maximum payment is $75 per prescription or refill. **Maintenance Drug:** 50% of the Prescription Drug Allowed Benefit per prescription or refill. The Member's minimum payment is $20 per prescription or refill. The Member's maximum payment is $150 per prescription or refill.
Specialty Drugs	Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network. Coverage for Specialty Drugs will **not** be provided when a Member purchases Specialty Drugs from a Pharmacy **outside** of the Exclusive Specialty Pharmacy Network.	**Non-Maintenance Drug:** 50% of the Prescription Drug Allowed Benefit per prescription or refill. The Member's minimum payment is $10 per prescription or refill. The Member's maximum payment is $75 per prescription or refill. **Maintenance Drug:** 50% of the Prescription Drug Allowed Benefit per prescription or refill. The Member's minimum payment is $20 per prescription or refill. The Member's maximum payment is $150 per prescription or refill.

1. The Member must pay the Copayment or Coinsurance at the time that a prescription is filled by the Pharmacist.

2. For Prescription Drugs, there is one Copayment due for each thirty-four (34) day supply. For Maintenance Drugs, a Member may receive up to a ninety (90) day supply provided the Member pays one Copayment for the first thirty-four (34) day supply and a second Copayment for a supply of thirty-five (35) days or more.

3. For Specialty Drugs, there is one Copayment due for each thirty-four (34) day supply. For Maintenance Drugs, a Member may receive up to a ninety (90) day supply provided the Member pays one Copayment for the first thirty-four (34) day supply and a second Copayment for a supply of thirty-five (35) days or more.

4. Contraceptive drugs and devices on the Preferred Preventive Drug List are not subject to a Copayment or Coinsurance. There is one Copayment due for a three (3) -month supply of oral contraceptive medications that are Brand Name Drugs that are not on the Preferred Preventive Drug List.

5. If the cost of the Prescription Drug is less than the Copayment or Coinsurance stated above, then the cost of the Prescription Drug will be payable by the Member at the time the prescription is filled.

6. Diabetic Supplies are not subject to any Copayment or Coinsurance.

7. Oral chemotherapy drugs are not subject to any Copayment or Coinsurance.

F. PRESCRIPTION DRUG DEDUCTIBLE

1. The Prescription Drug Deductible is the dollar amount that a Member will need to pay towards covered Prescription Drugs during a Benefit Period before any benefit for Prescription Drugs subject to the Prescription Drug Deductible is provided under this rider, unless the applicable Out-of-Pocket Maximum has otherwise been met.

2. The individual Prescription Drug Deductible is $100. The Member must meet the individual Prescription Drug Deductible before any benefit for Prescription Drugs subject to the Prescription Drug Deductible will be provided for that individual Member under this rider.

3. The family Prescription Drug Deductible is $200. Each Member can satisfy his/her own individual Prescription Drug Deductible for covered Prescription Drugs by meeting the individual Prescription Drug Deductible stated in Paragraph 2 above. In addition, eligible expenses of all covered family Members can be combined to satisfy the family Prescription Drug Deductible. Except as provided below, an individual family member cannot contribute more than the individual Prescription Drug Deductible stated above toward meeting the family Prescription Drug Deductible. Once the family Prescription Drug Deductible has been met, this will satisfy the family Deductible for all covered family Members.

   Under no circumstances shall the combined eligible expenses incurred by covered family Members exceed the family Prescription Drug Deductible. Once the eligible expenses of any covered family Member or a combination of two or more covered family Members meets the family Prescription Drug Deductible, this satisfies the family Prescription Drug Deductible for all covered family members.

4. The following amounts may not be used to satisfy the individual or family Prescription Drug Deductible:

   a. Charges in excess of the Allowed Benefit paid to a non-Contracting Pharmacy.

   b. Amounts incurred for Prescription Drugs, including Specialty Drugs that are excluded from coverage under this rider.

c. Copayments or Coinsurance incurred by the Member for covered Prescription Drugs not subject to the Deductible.

d. 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.

e. Amounts incurred, or that would have been incurred, by the Member for failure to comply with prior authorization requirements for a Prescription Drug on the Prior Authorization List.

5. The following Prescription Drugs or other items covered under this rider, are not subject to the Prescription Drug Deductible:

a. Diabetic Supplies;

b. Oral chemotherapy drugs; and

c. Preferred Preventive Drugs.

G. PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM

1. The Prescription Drug Out-of-Pocket Maximum is the maximum dollar amount that a Member will need to pay towards Prescription Drugs during a Benefit Period. Once the Prescription Drug Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible, Copayment or Coinsurance for benefits under this rider.

2. The individual Prescription Drug Out-of-Pocket Maximum is $4,500. The Member must meet the individual Out-of-Pocket Maximum before CareFirst waives payment of the listed amounts applying to the Prescription Drug Out-of-Pocket Maximum.

3. The family Prescription Drug Out-of-Pocket Maximum is $9,000. Each Member can satisfy his/her own individual Prescription Drug Out-of-Pocket Maximum for covered Prescription Drugs by meeting the individual Prescription Drug Out-of-Pocket Maximum stated in Paragraph 2 above. In addition, eligible expenses of all covered family Members can be combined to satisfy the family Prescription Drug Out-of-Pocket Maximum. Except as provided below, an individual family member cannot contribute more than the individual Prescription Drug Out-of-Pocket Maximum stated above toward meeting the family Prescription Drug Out-of-Pocket Maximum. Once the family Prescription Drug Out-of-Pocket Maximum has been met, this will satisfy the family Prescription Drug Out-of-Pocket Maximum for all covered family Members.

   Under no circumstances shall the combined eligible expenses incurred by covered family Members exceed the family Prescription Drug Out-of-Pocket Maximum. Once the eligible expenses of any covered family Member or a combination of two or more covered family Members meets the family Prescription Drug Out-of-Pocket Maximum, this satisfies the family Prescription Drug Out-of-Pocket Maximum for all covered family members.

4. The following amounts apply to the Prescription Drug Out-of-Pocket Maximum:

   Copayments and Coinsurance for Prescription Drugs covered under this rider.

5. The following amounts may not be used to satisfy the Prescription Drug Out-of-Pocket Maximum:

   a. Charges in excess of the Allowed Benefit paid to a non-Contracting Pharmacy.

b. Amounts incurred for Prescription Drugs, including Specialty Drug that are excluded from coverage under this rider.

c. 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.

d. Amounts incurred by the Member for failure to comply with prior authorization requirements for a Prescription Drug on the Prior Authorization List.

H. EXCLUSIONS

Benefits will not be provided under this rider for:

1. Benefits will not be provided for Specialty Drugs obtained from a Pharmacy that is not part of the Exclusive Specialty Pharmacy Network.

2. Any devices, appliances, supplies, and equipment except as otherwise provided in Section B, above.

3. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.

4. Prescription Drugs for cosmetic use.

5. Prescription Drugs administered by a physician or dispensed in a physician's office.

6. Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst.

7. Except for items included on the Preferred Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.

8. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
   a. Prenatal vitamins.
   b. Fluoride and fluoride containing vitamins.
   c. Single entity vitamins, such as Rocaltrol and DHT.
   d. Vitamins included on the Preferred Preventive Drug List.

9. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage

10. Any portion of a Prescription Drug that exceeds:
    a. a thirty-four (34) day supply for Prescription Drugs; or,
    b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst.

11. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.

12. Prescription Drugs for weight loss.

13. Biologicals and allergy extracts.

14. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

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

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

An independent licensee of the Blue Cross Blue Shield Association

MORBID OBESITY SURGERY BENEFIT AMENDMENT

This amendment is effective August 1, 2017.

I. Description of Covered Services is amended to add the following:

A. Surgical Treatment of Morbid Obesity. Benefits are provided for the surgical treatment of Morbid Obesity. 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.

Morbid Obesity means:

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

As used above, body mass index (BMI) is the practical marker used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Benefits are subject to the same terms and conditions as other Medically Necessary surgical procedures.

B. 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 19. Benefits for preventive care and screening for obesity are available to all Members.

6. Benefits for Prevention and Treatment of Obesity are available to the same extent as office visit benefits provided for preventive care services.

C. Professional Nutritional Counseling and Medical Nutritional Therapy.

1. Definitions

Professional Nutritional Counseling means individualized advice and guidance given to a Member 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.

Medical Nutrition Therapy, provided by a licensed dietitian-nutritionist, 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, take 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.

2. Covered Services. Benefits are available for Medically Necessary Professional Nutritional Counseling and Medical Nutrition Therapy as determined by CareFirst BlueChoice.

3. Benefits for Professional Nutritional Counseling and Medical Nutrition Therapy are available to the same extent as benefits provided for PCP office visits for medical treatment.

II. The Description of Covered Services, Section 10.1.P is deleted and replaced with the following:

P. Medical treatment for obesity, weight reduction, dietary control or commercial weight loss programs. This exclusion does not apply to:

1. Well child care visits 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;

4. Office visits for the treatment of childhood obesity;

5. Professional Nutritional Counseling and Medical Nutrition Therapy; and

6. Surgical treatment of Morbid Obesity.

III. The Schedule of Benefits is amended to add the following:

BENEFITS				
Unless otherwise stated, all Member payments shown are in addition to any applicable Deductible.				
Service	**Limit on Benefits** (In-Network and Out-of-Network combined)	**CareFirst Covers**		
		In-Network	**Subject To Deductible**	**Out-Of Network**
Surgical Treatment of Morbid Obesity		90% of the Allowed Benefit	In-Network and Out-of-Network Deductibles apply	70% of the Allowed Benefit

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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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 wellness-related 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.

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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 Plus Provider means a CareFirst provider who contracted to be a PCMH Plus Provider. Members receive an increased Annual Incentive for using a PCMH Plus Provider when completing the incentive activities and requirements.

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) diagnostic screening 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. A Dependent Child is not eligible for any incentive amounts under this rider.

1. Select a PCMH PCP or PCMH Plus Provider.

A Member must select a PCMH PCP or PCMH Plus Provider within 120 days of enrollment or renewal. Members earn a greater incentive for selecting a PCMH Plus Provider.

2. Wellness Visit to PCMH PCP or PCMH Plus Provider and Diagnostic Screening.

A Member must visit the selected PCMH PCP or PCMH Plus Provider for the Member's annual wellness visit and complete the 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 selected PCMH PCP or PCMH Plus Provider 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 than 30 (age 18 and older) From 5th to 85th percentile (until age 18)
2. Blood Pressure	Less than 140/90 (until age 59) Less than 150/90 (age 60 and older)
3. Blood Glucose	Less than 126 (fasting) Less than 200 (non-fasting)
4. Tobacco	Non User
5. Influenza Immunization	Annual

Upon request, or if the Eligible Member does not meet the targets stated in the chart, CareFirst will provide a reasonable alternative standard to, or waiver of, the targets listed in the chart. The Eligible Member's PCMH PCP or PCMH Plus Provider shall develop the reasonable alternative standard. The Eligible Member shall then be rescreened at a time determined by the Eligible Member's PCMH PCP or PCMH Plus Provider and such provider shall determine whether the Eligible Member has satisfied the reasonable alternative standard.

To request a reasonable alternative standard, the Eligible Member and PCMH PCP or PCMH Plus Provider shall complete the CareFirst 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, which may be submitted by logging into *My Account* at www.carefirst.com.

At the time determined by the Eligible Member's PCMH PCP or PCMH Plus Provider, the Eligible Member shall be rescreened and a second version of the CareFirst Health and Wellness form shall be completed noting whether the alternative standard was met. The completed form must be submitted by the Eligible Member, which may be submitted 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 or PCMH Plus Provider 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 a maximum incentive of $100 per Benefit Period.:

   Eligible Members will be issued the Annual Incentive on an individual basis as the credit is earned.

2. PCMH Plus Provider. Members who select a PCMH Plus Provider and complete the participation requirements in Section B will receive the Annual Incentive in the form of a medical expense debit card equal to a maximum incentive of $200 per Benefit Period.:

   Eligible Members will be issued the Annual Incentive on an individual basis as the credit is earned.

3. 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 a maximum incentive of $200 per Benefit Period if the Member selected a PCMH PCP and $400 if the Member selected a PCMH Plus Provider.

   Eligible Members will be issued the wellness incentive on an individual basis as the incentive is earned.

4. Maximum Annual Incentive. The total Maximum Annual Incentive may not exceed $1,500 per family for completion of all participation and outcomes-based incentives, including a $500 maximum for participation-only incentives and a $1,000 maximum for outcomes-only incentives. If the award of the Annual Incentive to an Eligible Member exceeds the Maximum Annual Incentive allowed for a family, the Annual Incentive awarded to the Eligible Member will be reduced to comply with the Maximum Annual Incentive.

E. CONDITIONS AND LIMITATIONS

1. Members are eligible to qualify for each incentive once per Benefit Period.

2. Providers may join or leave the PCMH program or be designated a PCMH Plus Provider at any time. To earn the Annual Incentive, a Member must select a Primary Care Provider who is a PCMH PCP or PCMH Plus Provider at the time the selection is made.

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. If a Member chooses to complete the Health Assessment diagnostic screening requirements in Section B.2 through the selected PCMH PCP or PCMH Plus Provider, but the Member is unable to obtain an appointment with the selected PCP within the

timeframes set forth in Section B, the Member can satisfy the incentive requirements by receiving the required services from any PCP in the PCMH PCP or PCMH Plus Provider's panel within the required timeframes.

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:

   a) cannot be used to pay for qualified medical expenses or other cost-sharing responsibilities unless (i) the Member first satisfies his/her minimum deductible as established by the Internal Revenue Service or (ii) the Member provides a signed agreement stating that he/she has not funded and agrees not to fund an HSA account during the Benefit Period; and

   b) can be used to pay for eligible dental and vision expenses that are part of the Member's benefit plan.

9. Members may satisfy the Health Assessment diagnostic screening requirement in Section B.2 process approved by CareFirst, so long as the Member consents to share the results, and shares the results, with the Member's PCMH PCP or PCMH PCP Plus Provider within the designated timeframes to qualify for the wellness incentive.

10. If the coverage allows for out-of-area benefits that extend beyond Emergency Services and Urgent Care, Members residing outside of CareFirst's service area will earn the participation incentive by selecting a participating provider in a PCP-like specialty (family practice, general practice, internist, geriatrics, pediatrics) in the Blue Cross and Blue Shield Plan where the Member resides and completing the activities identified in Section B. Members residing outside of CareFirst's service area are eligible for the outcome incentives, but are not eligible for the greater incentive provided for selecting a PCMH Plus Provider.

11. Only a Subscriber and Subscriber's Dependent Spouse, or, if applicable, the Subscriber's Dependent Domestic Partner, are eligible for incentives under this rider. Dependent Children are not eligible for any incentives under this rider.

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ATTACHMENT D
ELIGIBILITY SCHEDULE

Effective Date	Effective as of the Effective Date of Your Contract
ELIGIBILITY	
Subscriber	A full-time wage-earning employee; who works at least 30 hours per week on a regular (not seasonal or temporary) basis. An eligible employee or eligible participant of the Group, who is subject to the provisions of the Family and Medical Leave Act of 1993, as stated therein. NOTE: A wage earning employee is a person who is compensated for work/services performed in accordance with applicable federal and state wage and hour laws, which compensation is reported to the Internal Revenue Service by Form W-2. A part-time wage-earning employee who works at least 40 hours per pay period for 90 days or more. Retirees and eligible dependents are covered either under group coverage or Medicare supplemental coverage and pay the full premium. An employee who terminated employment due to disability prior to or on or after the effective date of group's coverage. Disabled employees are eligible for coverage up to age 65. Fellows and Scholars are effective on the date of hire also known as the date of fellowship/scholarship but must enroll within 30 days of date of fellowship/scholarship. Trust employees considered disabled under the Trust long term disability plan pay the active employee rate. Are covered up to age 65 as long as they continue to be considered disabled under the definition of the Trust employee long term disability plan.

	Temporary Federal employees with an appointment of at least one year. Must pay the full premium. Coverage is effective the first of the month following receipt of application if received within 60 days from date of hire. Eligibility will cease when an employee's hours fall below 20 hours per week unless they are in a stability period, for which they were found to be eligible for the prior measurement period. All other employees are eligible for coverage on the first day of the pay period following receipt of application in the benefits office. Surviving spouses are eligible for coverage.
Spouse	Coverage for a spouse is available.
Dependent Children	Coverage for Dependent children is available.
Type of Coverage	Individual, Family
Limiting Age for Dependent children (other than incapacitated children)	Up to age 26
[Limiting Age for Student Dependents	Up to age 26
EFFECTIVE DATES	
Open Enrollment Effective Date	The Group's Effective Date
Existing Subscriber Effective Date	An existing Subscriber is eligible for coverage on the Effective Date of the Group
Existing Dependent Effective Date	An existing Dependent is eligible for coverage on the Effective Date of the Group.
New Subscriber Eligibility Date	A new employee or other new participant of the Group is eligible for coverage effective first day of the pay period following receipt of application must enroll within 60 days from date of hire. For employees who become eligible due to change in status, the effective date will be the first day of the pay period following receipt of application (must enroll within 60 days from date of change in status). If a Section 125 Plan, within 31 days after any event which, in the judgment of the Plan Administrator qualifies as a status change or other allowable change under Section 125 of the Internal Revenue Code (family status changes) a new Subscriber is eligible for coverage effective the first of the month following acceptance of the enrollment form by CareFirst.
Newly eligible Dependent child (newborn, newly adopted child, Dependent child for whom guardianship has been granted by court or testamentary appointment, stepchild, Primary Care Dependent, or child subject to a MCSO/QMSO)	Newly born Dependent child: the date of birth. 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. Testamentary or court appointed guardianship of a

	Dependent child: the date of appointment. A stepchild or a Primary Care Dependent of the Subscriber: the date the stepchild or Primary Care Dependent became a Dependent of the Subscriber or Dependent Spouse . 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: Medical Child Support Order: the date specified in the Medical Child Support Order. Qualified Medical Support Order: the date specified in the Medical Child Support Order.
New Dependent (other than newborn, newly adopted child, Dependent child for whom guardianship has been granted by court or testamentary appointment, stepchild, Primary Care Dependent, or child subject to a MCSO/QMSO)	The date first eligible.
Special Enrollment Periods	
Subscribers who are eligible for special enrollment (except for those who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility)	The employee must notify the Group, and the Group must notify CareFirst no later than 31 days after (1) the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described; (2) the termination of employer contributions toward that other coverage; or (3) a person becomes a newly-eligible Dependent of the Subscriber through marriage, or becomes a newly-eligible Dependent child of the Subscriber. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least 31 days after a claim is denied due to the operation of a lifetime limit on all benefits. Coverage for a new Subscriber eligible for special enrollment is effective on the first of the month following acceptance of the enrollment form by CareFirst or, when a person becomes a newly-eligible Dependent through marriage or a newly-eligible Dependent child of the Subscriber, the date specified for Dependents who are eligible for special enrollment below.

Dependents who are eligible for special enrollment (except for those who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility)	In the case of a Dependent who loses coverage and is eligible for special enrollment, the employee must notify the Group, and the Group must notify CareFirst no later than 31 days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least 31 days after a claim is denied due to the operation of a lifetime limit on all benefits. Coverage for a Dependent who loses coverage and is eligible for special enrollment is effective on the first of the month following acceptance of the enrollment form by CareFirst. In the case of a newly-eligible Dependent (newly-eligible spouse or newly-eligible Dependent child), the employee must notify the Group, and the Group must notify CareFirst during the 31-day special enrollment period beginning on the date of the marriage; the date of birth; the date of adoption or placement for adoption; in the case of a Primary Care Dependent, the date upon which the Dependent became a Primary Care Dependent of the Subscriber or the Subscriber's spouse; in the case of a child that is the subject of a MCSO or QMSO, the date specified in the MCSO or QMSO; or, in the case of a minor for whom guardianship is granted by court or testamentary appointment, the date of appointment. Coverage for a newly-eligible Dependent who is eligible for special enrollment is effective as of the effective dates provided above for a Newly eligible Dependent child (newborn, newly adopted child, Dependent child for whom guardianship has been granted by court or testamentary appointment, Primary Care Dependent, or child subject to a MCSO/QMSO) or a New Dependent (other than newborn, newly adopted child, Dependent child for whom guardianship has been granted by court or testamentary appointment, Primary Care Dependent, or child subject to a MCSO/QMSO).
Subscribers and Dependents who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility	The employee must notify the Group, and the Group must notify CareFirst no later than 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. The employee must notify the Group, and the Group must notify CareFirst, no later than 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, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan). 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 COVERAGE	
Subscriber no longer eligible	Coverage ends on the last day of employment or eligibility.
Dependent children	On their 26th birthday.
Student Dependents	On their 26th birthday.
Other Dependent no longer eligible (includes marriage of child or divorce of spouse)	A Dependent will remain covered until the end of the month in which the Dependent no longer meets the eligibility requirements stated in the evidence of coverage.
Death of Subscriber	Coverage ends on the last day of the month after the Subscriber's death.