Montgomery County Government

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For Your Reference

Member Services Representatives are available to answer benefit and claim inquiries Monday through Friday from 7:00 a.m. until 10:00 p.m., Eastern Time (ET) and on Saturday 8:00 a.m. until 1:00 p.m., ET. In addition, a Voice Response Unit (VRU) is available from 7:00 a.m. to 11:00 p.m. ET, Monday through Friday and from 9:00 a.m. to 5:00 p.m. ET, Saturday for claims status and claim form requests. Please contact Member Services 888-417-8385.

You may also view the status of your claims by visiting our website at www.carefirst.com. Just go to *My Account* under the Members and Visitors portion of the website.

You can also send written inquiries to Member Services at:

Mail Administrator
PO Box 14115
Lexington, KY 40512-4115

To authorize medical services, please contact Utilization Management at 866-PREAUTH (773-2884).

To authorize inpatient mental health and substance abuse services, please contact Magellan Behavioral Health at 800-245-7013. Magellan Behavioral Health is an independent company and administers the prior authorization program for mental health and substance abuse services on behalf of CareFirst BlueCross BlueShield.

Introduction

Montgomery County Government is pleased to offer you and your family access to health care coverage. The Indemnity Program Option, administered by Claims Administrator, CareFirst BlueCross BlueShield, enables you to choose how to receive services based on your health care needs.

Overview	This Benefit Guide describes the benefits offered under this program. If you have a question that is not covered in this Benefit Guide, call Member Services at 888-417-8385. The Member Services number is also listed on the front of your identification card.
How to Use This Benefit Guide	This Benefit Guide is meant to be informative and easy to understand. It was written to help you learn how your benefits work and how to use them most effectively. The information provided in this Benefit Guide summarizes your benefit plan. It does not contain all of the details described in the official plan documents. If there is a discrepancy between what is summarized here and the official plan documents, the plan documents will govern. Montgomery County Government reserves the right to change, amend or terminate the program at any time. This Benefit Guide is not a contract and participation in this plan does not guarantee employment.
Understanding Key Terms	Certain key terms that relate to your benefits are used throughout this Benefit Guide. Those terms are defined in the Definitions Sections of the Program Description and within any Attachments.

Highlights of the Program Option

- The Program Option covers most of your health care needs and enables you to choose where to receive services:

  - from a Participating Provider;
  - from any other covered provider that CareFirst BlueCross BlueShield recognizes as an eligible covered provider of medical services (Non-Participating Provider).

- When you go to a Participating Provider, you are covered at a percentage of the billed charges after you have met your Annual Deductible. You will also have no claims to file. You or your participating provider must obtain any required authorization. When you go to a Non-Participating Provider you need to coordinate your own care and obtain any required authorization. You may need to pay for services up-front and then file claim forms for reimbursement.

- Covered services include:

  - physician office visits
  - laboratory tests and x-rays
  - preventive care
  - inpatient and outpatient hospital services
  - mental health and substance abuse services

How the Program Works

Participating vs. Non-Participating Providers

You have coverage under the Program. With this plan, you can decide where you want to receive care each time you need it. Because CareFirst BlueCross BlueShield has special arrangements with some providers, called Participating Providers, your out-of-pocket costs may be lower if you choose a Participating Provider over a Non-Participating Provider.

Seeing a Participating Provider

All Participating Providers are licensed doctors/practitioners or facility/hospitals invited to join CareFirst BlueCross BlueShield's network after a careful screening of credentials. Participating Providers have agreed to deliver services covered by the Program to Members at a fixed cost, known as the Allowed Benefit**.** You will not be billed by a Participating Provider for any amount over the Allowed Benefit. Your only out-of-pocket costs will be your Coinsurance after meeting your Annual Deductible**.** You or the Participating Provider will need to obtain any authorization that may be necessary, but you do not need to file any claims. Call 888-417-8385 to determine if your physician is a participating provider.

Seeing a Non-Participating Provider

When you choose to see a Non-Participating Provider, you can see any covered provider. If you see a Non-Participating Provider, you may have to pay for your services up-front and submit a claim form for reimbursement up to the Allowed Benefit, less any coinsurance that may apply. If the provider's fees exceed the Allowed Benefit, you may have to pay the difference. You will need to obtain any authorization required. (For more information on how to submit a claim, see page 7.)

Out-of-Pocket Costs

You will be responsible for paying a portion of your health care expenses as described below.

*Annual Deductible**

For many services, you must first meet an Annual Deductible before the Program will begin to provide benefits. The following deductibles will apply:

Deductibles	
Individual coverage	$200
Family coverage	$400

**You must meet the deductible every calendar year*

If you have individual coverage, you must meet the individual Deductible. If you have family coverage any combination of all covered Members can be combined to satisfy the Family Deductible. However, no one-person can contribute more than the individual deductible.

After you meet the deductible, you will also be responsible for any coinsurance that may apply.

Coinsurance For most services, you are responsible for a percentage of the cost of services you receive, called coinsurance.

If you go to a Participating Provider, the Program will cover a percentage of the Allowed Benefit for covered services you or your covered Dependents receive. You will usually pay 20% of the Allowed Benefit, and the Program will pay 80%.

If you go to a Non-Participating Provider, the Program will pay a percentage of the cost for covered services, up to the Allowed Benefit. If your Non-Participating Provider charges more than the Allowed Benefit, you will be responsible for paying your percentage of the Allowed Benefit in addition to any charges above the allowance. This additional amount is not counted toward your Deductible or the annual out-of-pocket limit. Check the Schedule of Benefits for your Coinsurance for specific services.

Following are three examples that illustrate how to determine your out-of-pocket costs.

Example 1 - Let's assume:
1. You have family coverage
2. Your child is sick and needs to see a doctor
3. You choose to see a Participating Provider
4. The cost of the office visit is $70, and the Allowed Benefit for an office visit is $50
5. You have already met your family Deductible

Here's how you would calculate your out-of-pocket costs.

The Program pays	$40 (80% of $50)
You pay	**$10*** (20% of $50)

*You are not responsible for the difference ($20) between the actual charges ($70) and the Allowed Benefit.

Example 2 - Let's make the assumptions used in the above example, but use a Non-Participating Provider instead:
1. You have family coverage
2. Your child is sick and needs to see a doctor
3. You choose to see a Non-Participating Provider
4. The cost of the office visit is $70, and the Allowed Benefit for an office visit is $50
5. You have already met your family Deductible

Here's how you would calculate your out-of-pocket costs.

The Program pays	$40 (80% of $50)
You pay	**$30** (20% of $50 plus the $20 that your doctor charges over the Allowed Benefit)

Out-of-Pocket Limit To protect you and your family from the cost of a catastrophic illness or accident, there is a limit on the amount of out-of-pocket medical expenses you will be expected to incur for covered services every plan year — called the Out-of-Pocket Limit. After your costs reach the limit, the Program will pay 100% of your covered medical costs. The following Out-of-Pocket Limits will apply:

Out-of-Pocket Limits	
Individual maximum	$1,000

If you have family coverage, eligible expenses of all covered members can be combined to meet your family Out-of-Pocket Limit. However, one covered Dependent cannot contribute more than the Individual limit toward meeting the family limit.

Lifetime maximum The lifetime maximum is $1,000,000 per Member.

Filing a Claim

If you see a Non-Participating Provider, you are responsible for filing a claim form, or for ensuring that your doctor's office or hospital files one for you. As previously discussed, if you see a Participating Provider, you will not need to file a claim.

Claim forms are available from your employer or by calling CareFirst BlueCross BlueShield Member Services at 888-417-8385. Attach an itemized bill to your completed claim form and submit it to:

Mail Administrator
PO Box 14115
Lexington, KY 40512-4115

Claims must be submitted to CareFirst BlueCross BlueShield within 15 months of the date the services or supplies were received. CareFirst BlueCross BlueShield will only consider claims beyond the 15-month filing limit if you are legally incapacitated prior to the end of the filing period.

You should keep copies of all bills for your records. Your original bills will not be returned.

Commonly Asked Questions and Answers about Your Plan

Q.	**What is the difference between seeing a Participating Provider and a Non-Participating Provider?**
A.	When you go to a Participating Provider, you are covered at a percentage of the Allowed Benefit after you have met your Annual Deductible. Participating Providers have agreed to accept the Allowed Benefit as payment in full for covered services. You will also have no claims to file. You or your participating provider is required to obtain all authorizations. When you go to a Non-Participating Provider you need to coordinate your own care and obtain any required authorization. You may need to pay for services up-front and then file claim forms for reimbursement. Non-Participating Providers may not accept the Allowed Benefit as payment in full for covered services. You may be responsible for paying any additional charges. For a list of Participating Providers in your area, contact Member Service at 888-417-8385.

Q.	**My daughter is going away to college next year. Will she still be covered under my Plan?**
A.	Yes. Your child will be covered as long as she is a full-time student and meets the eligibility requirements of a Dependent Child. Completion of a student certification form, available from the Benefits Department is required.

Q.	**How do I know when I have to obtain special authorization to receive coverage?**
A.	You must get pre-authorization from the Utilization Management Department if you need inpatient admissions to a hospital, mental health and substance abuse services, skilled nursing facility services, home health services or hospice services. If you go to a Participating Provider, your doctor will arrange for pre-authorization. If you go to a Non-Participating Provider, you are responsible for calling Utilization Management at 866-PREAUTH (773-2884) and arranging your care. Remember to check the Description of Covered Services, Utilization Management Requirements Section for a comprehensive list of services that may require prior authorization.

Other Questions?

If you have questions about CareFirst BlueCross BlueShield, your options, covered services, your level of coverage, or any other aspect of your Program, call Member Services at 888-417-8385

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

An independent licensee of the Blue Cross and Blue Shield Association

MEDICARE CARVE-OUT AND MEDICARE SUPPLEMENTAL PROGRAM DESCRIPTION

CareFirst provides administrative claims payment services only and does not assume any financial risk or obligation with respect to those claims.

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

Members have no benefits after a Plan termination or partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial Plan termination and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state or local law.

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

SECTION 1
DEFINITIONS

This Program Description uses certain defined terms. When these words are capitalized, they have the following meanings.

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.

Anniversary Date means the date specified in the Administrative Service Agreement (ASA), on which the Contract renews and each annual anniversary of such date.

Benefit Guide means the summary description of the program provided to all Members. In the event of a conflict between the summary description and this complete Program Description, the language of this Program Description governs.

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

Claims Administrator means CareFirst.

Contract means the agreement issued by CareFirst to the Employee/Member's Group through which the benefits described in this Program Description are administered to the Employee/Member and his enrolled Dependents, if any. In addition to this Program Description, the Contract includes an Administrative Services Agreement, Attachments, any Riders or Amendments and the Benefit Guide.

Dependent means a person who meets the eligibility rules in Section 2, Eligibility and Enrollment.

Domestic Partner means a person who meets the eligibility rules in Section 2, Eligibility and Enrollment.

Effective Date means the date on which the Group Contract becomes effective and on which Members first become eligible to receive benefits and services under the Contract. The Effective Date is set forth in the Administrative Services Agreement.

Eligible Employee/Member means persons who meet the eligibility rules in Section 2, Eligibility and Enrollment.

Enrollment Application/Form means the information submitted by or on behalf of an eligible individual in connection with a request to enroll under the Contract as either an Employee/Member or a Dependent.

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.

Group Contract means the Contract issued by CareFirst to the Group/Sponsor.

Group/Sponsor means the Employee/Member's employer or other organization that sponsors a health benefits plan to which CareFirst has issued the Contract.

Hospital means any facility in which the primary function is the provision of diagnosis, treatment, and medical and nursing services, surgical or non-surgical and that is:

A. Licensed by the appropriate State authorities; or

B. Accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

C. Approved by Medicare.

The facility cannot be, other than incidentally: a convalescent home, convalescent rest or nursing facilities; facilities primarily affording custodial, educational or rehabilitative care; or facilities for the aged, drug addicts or alcoholics.

Limiting Age means the age to which a Subscriber may cover his/her unmarried Dependent Children as stated in Section 2, Eligibility and Enrollment.

Medical Director is 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.

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

Membership Categories are based upon whether the Employee/Member only or the Employee/Member and Dependents are enrolled. In addition, Membership Categories may distinguish which Dependents are enrolled along with the Employee/Member.

Membership Categories under the Contract are:

- **Individual Coverage**, which covers the Employee only;
- **Two-Party Coverage**, which covers the Employee and:
  - spouse; or

  - Domestic Partner; or
  - Dependent Child
- **Family Coverage**, which covers the Employee and two or more Dependents.

Additionally, **Retired** employees may elect one of the following:
- **Medicare Complementary** (entitled to Medicare Parts A & B): Coverage for Employee only
- **Individual + 1 Medicare** (One person has Medicare coverage) Coverage for the Employee and**:**
  - Spouse, Domestic Partner or eligible Dependent Children; or
  - Eligible Dependent Child
- **Two Medicare Complementary** (both persons have Medicare coverage) Coverage for Employee/Member and:
  - Spouse, Domestic Partner
  - Eligible Dependent Child

Paid Claims is the amount paid by CareFirst for Covered Services under the Plan. BlueCard Fees and Compensation and other payments relating to fees and programs applicable to CareFirst's role as Claims Administrator are also included in Paid Claims.

Plan means that portion of the welfare benefit plan established by the Group that provides for health care benefits for which CareFirst is the Claims Administrator under this Group Contract.

Plan Administrator means the person or persons designated by the Group.

Program Description means this document. In addition to this Program Description, the Contract includes an Administrative Services Agreement, Attachments, any Riders or Amendments and the Benefit Guide.

Subscriber means a Member who is covered under the Contract as an Employee/Member, rather than as a Dependent.

Waiting Period means the period of time that must pass before an employee or dependent is eligible to enroll under the terms of this Contract.

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage. The Group is required to administer all requirements for coverage in strict accordance with the terms that have been agreed to and cannot change the requirements for coverage or make an exception unless CareFirst approves them in advance, in writing. To be covered under the Contract, all of the following conditions must be met:

A. The individual must be eligible for coverage either as an Employee/Member pursuant to Section 2.2, below or, if applicable, as a spouse, Domestic Partner, Dependent or Dependent Child of a Domestic Partner pursuant to Section 2.3 or 2.4 below;

B. The individual must elect coverage during certain periods set aside for this purpose as described in Section 2.6, below;

C. The Group must notify CareFirst of the election in accordance with the Group Contract; and

D. Payments must be made by or on behalf of the Member as required by the Group Contract.

2.2 Eligibility as an Employee/Member. To be eligible as an Employee/Member, the individual must meet the basic requirements as stated below and any additional eligibility requirements to which the Group has agreed.

A. Employees who were hired by the Group prior to January 1, 1987 and who elect to retain, as Retirees, the Medicare Carve-Out Program (as described in Attachment C) in effect on December 31, 1986.

B. Employees who were hired by the Group on or after January 1, 1987, or were hired by the County prior to January 1, 1987 and have elected the Indemnity Supplemental Program (as described in Attachment D).

C. 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.

A wage earning employee is a person who is compensated by the Sponsor for work/services performed in accordance with applicable federal and state wage hour laws, which compensation is reported to the Internal Revenue Service by Form W-2 and the Department of Business and Economic Development by Form DEED/AU-16.

Directors, trustees, corporate officers, outside counsel, consultants, owners, partners, temporary or seasonal employees, etc. are not eligible employees, unless they are actually employed by the Group and meet the criteria for coverage applicable to other Group employees.

2.3 Eligibility of Employee/Member's Spouse or Domestic Partner. An Employee/Member may elect Family or Subscriber and spouse or Domestic Partner Coverage; an Employee/Member may cover his/her legal spouse or Domestic Partner as a Dependent. An Employee/Member cannot cover a former spouse once divorced or if the marriage has been annulled. If an Employee/Member is separated but still legally married, his or her spouse may still be covered.

2.4 Eligibility of Employee/Member's Dependent Children. The Group may elect to provide coverage for eligible Dependent Children including the Dependent Child of a Domestic Partner. To be eligible as a Dependent Child, the child must:

A. Meet the age requirements described in Section 2.5 below;

B. Be unmarried;

C. Be related to the Employee/Member, in one of the following ways:

1. A natural child;

2. A legally adopted child or grandchild;

3. A child (including a grandchild) for whom the Employee/Member is the legally recognized proposed adoptive parent and who is dependent upon and living with the Employee/Member during the waiting period before the Adoption becomes final;

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

5. A grandchild who is in the court ordered custody of and is dependent upon and residing with the Employee/Member;

6. A child for whom the Employee/Member has been court ordered or administratively ordered to provide coverage;

7. The child of the Employee/Member's Domestic Partner who permanently resides in the Employee/Member's household and is dependent upon the Employee/Member for more than half of his or her support.

D. Children whose relationship to the Employee/Member are not listed above, are not covered under the Contract, even though the child may live with the Employee/Member and be dependent upon the Employee/Member for support. CareFirst has a right to request documentation from the Employee/Member that a child qualifies for coverage as a Dependent.

2.5 Age Limits for Coverage of Dependent Children (Limiting Age). All Dependent Children are eligible for coverage up to the Limiting Age as stated below.

A. All Dependent Children are eligible up to age 19;

B. Dependent Children who are age 19 or over are eligible to be covered as Student Dependents up to age 26 if attending school, college or university on a full time basis. Student Dependent means a Dependent Child who is enrolled and whose time is principally devoted to attending school. The Member must provide Montgomery County Government with proof of the child's student status, as requested by the group, after the child's 19th birthday, or coverage would otherwise terminate or within 31 days after the Effective Date of the child's coverage under the Contract, whichever is later. Montgomery County Government has the right to verify whether the child is and continues to qualify as a Dependent or Student Dependent.

C. A Dependent Child will be eligible for coverage past the Limiting Age of 19if:

1. The child is incapable of supporting him or herself because of mental or physical disability;

2. The disability occurred before the child reached the Limiting Age or, if the child was covered beyond the Limiting Age as a non-Student or Student Dependent, the disability occurred before the child reached the Limiting Age;

3. The child is primarily dependent upon the Employee/Member or the Employee/Member's spouse or Domestic Partner for support and maintenance; and

4. The Member provides CareFirst with proof of the child's certified medical incapacity, within 31 days after the child's coverage would otherwise terminate or

within 31 days after the Effective Date of the child's coverage under the Contract, whichever is later. CareFirst has the right to verify whether the child is and continues to qualify as an incapacitated child.

2.6 Enrollment Requirements. Eligible individuals may elect coverage as Employee/Members or Dependents, as applicable, only during the following times and under the following conditions:

A. **Annual Open Enrollment**. Prior to January 1 of each year that the Group Contract is in effect, the Group will have an Open Enrollment Period as announced by the Group. During the Open Enrollment Period, Eligible Subscribers who are not covered may enroll themselves and their Dependents in the Plan. In addition, Employee/Members already enrolled in CareFirst may change their Membership Category (e.g., from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage or change plan options. Your coverage will become effective on January 1.

B. **Newly Eligible Employee/Member**. Newly eligible individuals may enroll within 60 days after they first become eligible as determined within Section 2, Eligibility and Enrollment. If such individuals do not enroll within this period and do not qualify for the Special Enrollment Period as described in Section 2.6.E, Special Enrollment Periods, they must wait for the Group's next open enrollment period.

C. **Coverage of a Newborn, Newly Adopted Child, Newly Eligible Grandchild or a Minor to whom Guardianship is granted by Court or Testamentary Appointment**. Employee/Members may enroll new family members, such as an eligible newborn child, newly adopted child, newly eligible grandchild or a minor for whom guardianship is granted by court or testamentary appointment and/or change their Membership Category to include the new family member within 60 days following the date the new family member first becomes eligible. If this election is not made within this period and the new family member does not qualify for the Special Enrollment Period as described in Section 2.6.E, the new family member(s) may not enroll until the Group's next open enrollment period. The date of the child's First Eligibility Date is defined below:

First Eligibility Date:

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

2. For a newly adopted child, the earlier of; a judicial decree of Adoption; or date of assumption of custody, pending Adoption of a prospective adoptive child by a prospective adoptive parent;

3. For a grandchild for whom the Employee/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 for whom guardianship has been granted by court or testamentary appointment, the date of the appointment.

Family Coverage. If the Employee/Member is already enrolled under Family Coverage on the child's First Eligibility Date, an eligible newborn child, newly adopted child, newly eligible grandchild or a minor for whom guardianship has been granted by court or testamentary appointment will be covered automatically as of the child's First Eligibility Date.

Individual Coverage. If the Employee/Member is enrolled under Individual Coverage on the child's First Eligibility Date, the child will be covered automatically, but only for the first 31 days following the child's First Eligibility Date. The Employee/Member may continue coverage beyond this 31 day period, but the Employee/Member must enroll the child within 60 days following the child's First Eligibility Date. Premium changes

resulting from the addition of the child will be effective as of the child's First Eligibility Date.

Two-Party Coverage. If the Employee/Member is enrolled under Two-Party coverage (e.g., Individual and Adult or Domestic Partner or Individual and one child) on the child's First Eligibility Date, the child will be covered automatically as of the child's First Eligibility Date. However, if adding the child to the coverage results in a change in the Employee/Member's Membership Category (e.g., from Two-Party coverage to Family Coverage), the child's automatic coverage will end on the 31st day following the child's First Eligibility Date. If the Member wishes to continue coverage beyond this 31 day period, they must enroll him or her within 60 days following the First Eligibility Date. The change in the Membership Category and corresponding premium for the Employee/Member's new Membership Category will be made effective as of the child's First Eligibility Date.

D. **New Family Member (Other than a newborn or newly adopted child or newly eligible grandchild or a minor to whom guardianship is granted by court or testamentary appointment).** The Employee/Member may enroll new family members, such as a new spouse, Domestic Partner or stepchild, and/or change the Membership Category to include the new family member within 60 days following the date the new family member first becomes eligible. If this election is not made within this period and the new family member does not qualify for the Special Enrollment Period as described in Section 2.6.E, the new family member(s) may not enroll until the Group's next open enrollment period.

First Eligibility Date:

1. Spouse - The date the marriage is legally recognized.

2. Domestic Partner - The date established by the Group's enrollment procedures.

3. Stepchild or child of a Domestic Partner - If the child meets the definition of a Dependent Child under Section 2.4, the First Eligibility Date will be the same as that of the spouse or Domestic Partner. Otherwise, the First Eligibility Date for the child will be the date on which the child first meets the definition of Dependent Child under Section 2.4.

E. **Special Enrollment Periods.** Special enrollment is allowed for certain individuals who lose coverage. Special enrollment is also allowed with respect to certain Dependent beneficiaries.

1. Special enrollment for certain individuals who lose coverage:

   a. 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 Contract.

   b. Individuals eligible for special enrollment.

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

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

         b) When coverage was previously offered, the employee had

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

c) The employee satisfies the conditions of paragraph 1.c.1), 2), or 3) of this section, and if applicable, paragraph 1.c)4) of this section.

2) When Dependent loses coverage.

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

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

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

iii) The Dependent satisfies the conditions of paragraph 1.c)1), 2), or 3) of this section, and if applicable, paragraph 1.c)4) of this section.

b) However, CareFirst is not required to enroll any other Dependent unless the Dependent satisfies the criteria of this paragraph 1.b.2), or the employee satisfies the criteria of paragraph 1.b.1) of this section.

c. Conditions for special enrollment.

1) 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.1) 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:

a) 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;

b) 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);

c) 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;

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

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

2) 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.

3) 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)1) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.

4) 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.)

2. Special enrollment with respect to certain Dependent beneficiaries:

   a. 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 Contract.

   b. 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 2.b.1), 2), 3), 4), 5), or 6) of this section.

      1) 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.

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

         a) The individual becomes the spouse of a participant; or

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

      3) Current employee and spouse or Domestic Partner. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:

         a) The employee and the spouse become married; or

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

      4) 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.

      5) 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.

      6) Current employee, spouse or Domestic Partner, 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.

First Eligibility Date:

1. Special enrollment for certain individuals who lose coverage

The employee must notify the Group, and the Group must notify CareFirst no later than 30 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 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

A new Subscriber and/or his/her Dependent(s) are effective on the date defined by the Group.

2. Special enrollment for certain Dependent beneficiaries

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, birth, or Adoption or placement for Adoption

Dependents are effective as follows:

In the case of marriage: the date of marriage.

In the case of a newly born child: the date of birth.

In the case of an adopted 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.

F. Special enrollment regarding Medicaid and CHIP termination or eligibility \effective April 1, 2009.

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

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

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

2. Notification Requirement.

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

   b. The employee must notify the Group, and the Group must notify CareFirst, no later than 60 days after the date the employee or dependent is determined to be eligible for premium assistance, with respect to coverage under this Contract, 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 employee 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 employee'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 employee or Dependent is determined to be eligible for premium assistance with respect to coverage under this Contract.

2.7 Effective Dates. Coverage for an Employee/Member or his or her Dependents will become effective as stated below as long as the Enrollment Requirements in Section 2.6 are satisfied.

A. **Open Enrollment Effective Date**. Enrollment or changes in enrollment will be effective January 1, 2008, which is the Group's Open Enrollment Effective Date/Anniversary Date, if the requirements of Section 2.6.A are met.

B. **New Employee/Members.** Coverage of new Employee/Members will be made effective on the date as determined by the Employee/Members Office of Human Resources, if the requirements of Section 2.6.B are met.

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 Employee/Member is eligible for coverage effective on the date as determined by the Employee/Members Office of Human Resources.

C. **Coverage of Newborn Children, Newly Adopted Children and Newly Eligible Grandchildren**. Coverage will become effective as of the child's First Eligibility Date as stated in Section 2.6.C, if the requirements of Section 2.6.C are met.

D. **Coverage of Other Newly Eligible Dependents**. Coverage of other newly eligible Dependents; e.g., a new spouse, Domestic Partner, stepchild or child of a Domestic Partner, will be made effective in accordance with the Eligibility Date stated in Section 2.6., provided the newly eligible Dependent is enrolled within 60 days following the date upon which the Dependent first became eligible.

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 Employee/Member is eligible for coverage effective on the date as determined by the Employee/Members Office of Human Resources.

2.8 Employee/Member's Coverage Changes. When the Employee/Member's Membership Category is changed (e.g., from Individual to Family coverage) the change may become effective on any day throughout the month. Charges for Members enrolled during the month will be calculated on a pro-rata basis unless otherwise agreed to between the Group and CareFirst.

2.9 Domestic Partner Eligibility. The Group and CareFirst may require proof of any of the following qualifications at any time:

A. **Eligibility of Employee/Member's Domestic Partner**. The following persons are also eligible for benefits under the Contract:

1. The Subscriber's Domestic Partner.

2. The Eligible Dependents of a Domestic Partner.

A Domestic Partner and the Eligible Dependents of a Domestic Partner remain eligible only for the period that the Domestic Partnership continues.

A person who is related to the Subscriber; e.g., parent, grandparent, sibling, cousin, aunt, uncle, etc. is not eligible.

B. **Definitions**

Domestic Partner is a person who cohabitates/resides with the Subscriber in a Domestic Partnership and the Eligible Dependents of a Domestic Partner.

Eligible Dependent of a Domestic Partner is an unmarried person who has the same relationship to a Domestic Partner that is required of an Employee/Member's Dependent Children as defined herein.

Domestic Partnership is a relationship between a Domestic Partner and a Subscriber both of whom have signed the appropriate affidavit, enrollment application, or other document(s) required by the Group confirming their Domestic Partnership and that satisfies the following requirements:

1. They are the same sex (or opposite sex for members of the Fraternal Order of Police, effective July 1, 2001 and for members of the International Association of Fire Fighters, effective July 1, 2002);

2. They share a close personal relationship and be responsible for each other's welfare;

3. They have shared the same legal residence for at least 12 months;

4. They are at least 18 years old;

5. They have voluntarily consented to the relationship, without fraud or duress;

6. They are not married to, or in a domestic partnership with, any other person;

7. They have not related by blood or affinity in a way that would disqualify them from marriage under State law if the employee and partner were opposite sexes;

8. They are legally competent to contract;

9. They share sufficient financial and legal obligations; or

10. They have legally registered the Domestic Partnership, if

    a. A Domestic Partnership registration system exist in the jurisdiction where the employee resides; and

    b. The Office of Human Resources determines that the legal requirements for registration are substantially similar to the requirements listed under 1 above.

The Employee/Member must provide evidence of the Domestic Partnership. The Employee/Member must provide the following:

1. The Affidavit For Domestic Partnership signed in the presence of a notary public by both the Employee/Member and the Employee/Member's Domestic Partner under penalty of perjury declaring that they satisfy the requirements of Domestic Partnership; or

2. An official copy of the Domestic Partnership registration, and;

3. Evidence that the Employee/Member and the Domestic Partner share items described in at least 2 of the following (this requirement does not apply to a qualified, registered domestic partnership):

   a. Joint housing lease, mortgage, or deed;

   b. Joint ownership of a motor vehicle;

   c. Joint checking or credit account;

   d. Designation of the partner as the primary beneficiary of the employee's life insurance, retirement benefits, or residuary estate under a will; or;

   e. Designation of the partner as holding a durable power of attorney for health care decisions regarding the employee.

C. **Enrollment Requirements and Effective Date**. A Domestic Partner must:

1. File a notarized Affidavit For Domestic Partnership, with all required supporting evidence with the Office of Human Resources (affidavit form is attached);

2. Within 60 days of filing the affidavit with all required supporting evidence,

   - Complete a benefit enrollment form, when changing your level of coverage due to the addition of the Domestic Partner and Eligible Dependents of a Domestic Partner;

   - Complete a dependent information form to add the Domestic Partner and Eligible Dependents of a Domestic Partner (Note - Proof of eligibility, such as a birth certificate, is required to add Eligible Dependents of a Domestic Partner to the group insurance plans); and

   - Complete any forms required by the group insurance plan to add Eligible Dependents of a Domestic Partner.

Eligible Dependents of a Domestic Partner are enrolled in the same manner as a child and will have the same Effective Dates as a child.

D. **Termination of Coverage**. The Subscriber agrees to notify the Group in writing of the termination of the Domestic Partnership within 30 days of the date of termination. Coverage under the Contract for a Domestic Partner and any Eligible Dependents of a Domestic Partner will be terminated upon the termination of the Domestic Partnership. Otherwise, coverage under the Contract will be terminated under the same circumstances as any other Member.

E. **Continuation Privilege**. A Domestic Partner and the Eligible Dependents of a Domestic Partner are eligible for Continuation of Coverage under Federal Law.

F. **Conversion Privilege**. A Domestic Partner and the Eligible Dependents of a Domestic Partner are eligible for the Conversion Privilege of the Contract.

SECTION 3
MEDICAL CHILD SUPPORT ORDERS

3.1 Definitions

A. **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:

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

2. 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.

B. **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 The Child Support Performance and Incentive Act of 1998, as amended.

3.2 Eligibility and Termination

A. Upon receipt of a MCSO/QMSO, when coverage of the Subscriber's family members is available under the terms of the Subscriber's contract then CareFirst will accept enrollment regardless of enrollment period restrictions. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any State or the District of Columbia. If the Subscriber has not completed any applicable waiting periods for coverage, the child will not be enrolled until the end of the waiting period.

The Subscriber must be enrolled under this 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.

First Eligibility Date:

1. Medical Child Support Order: the date specified in the Medical Child Support Order.

2. Qualified Medical Support Order: the date specified in the Medical Child Support Order.

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

1. Was born out of wedlock.

2. Is not claimed as a dependent on the Subscriber's federal tax return.

3. Does not reside with the Subscriber.

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

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

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

2. 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; or,

3. If coverage is provided under an employer sponsored health plan;

   a. The employer has eliminated family member coverage for all employees; or

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

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

A. Send the non-insuring custodial parent ID cards, claim forms, the applicable Benefit Guide or member contract and any information needed to obtain benefits;

B. Allow the non-insuring custodial parent or a provider of a covered service to submit a claim without the approval of the Subscriber;

C. Provide benefits directly to:

1. The non-insuring parent;

2. The provider of the covered services; or

3. The appropriate child support enforcement agency of any State or the District of Columbia.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Member Coverage by CareFirst.

A. CareFirst can terminate coverage if CareFirst determines:

1. The Member allowed another person to use his/her identification card or the Member used another person's identification card. The identification card must be returned to CareFirst upon request.

2. The Member made an intentional misrepresentation of information which was material to the acceptance of the application when the Member represented that all information contained in the Enrollment Application was true, correct and complete to the best of the Member's knowledge and belief.

3. The Member made an intentional misrepresentation of any information required by CareFirst on any forms or other written requests for data. Such information will include but not be limited to requests for medical information, coordination of benefits information, subrogation information if applicable, employment status and dependent eligibility status.

4. The Member or the Member's representative made fraudulent misstatements related to coverage or benefits under the Contract.

4.2 Termination of Coverage by the Employee/Member.

A. The Employee/Member can remove an eligible Dependent if the Employee/Member makes a written request to the Group, at least 31 days prior to the requested termination date.

B. CareFirst shall not be required to give notice of termination to the Employee/Member or Dependents as a result of the Employee/Member's written request for termination.

C. Except as otherwise provided all Employee/Member benefits under the Contract will end as stated below.

1. If the Subscriber's coverage under this Contract terminates:

   a. Coverage for all Members under this Contract will terminate on the date as determined by the Employee/Members Office of Human Resources.

2. If the Subscriber remains eligible for coverage under this Contract, but another Member's eligibility ceases:

   a. Coverage under this Contract will terminate as determined by the Employee/Members Office of Human Resources.

   b. Coverage for a Dependent Child will terminate as determined by the Employee/Members Office of Human Resources.

   c. Coverage for a Student Dependent will terminate as determined by the Employee/Members Office of Human Resources.

4.3 Loss of Eligibility as a Dependent. Coverage of Dependents will automatically terminate when the Dependent reaches the Limiting Age or there is a change in the Dependent's status or relationship to the Employee/Member such that the Dependent no longer meets the eligibility requirements of the Contract. Termination of Coverage of Dependents due to loss of eligibility will be effective as stated in Section 2, Eligibility and Enrollment.

A. It is the Employee/Member's responsibility to notify the Group, and the Group's responsibility to notify CareFirst, of any changes in the status of his/her Dependents that affect their eligibility for coverage under the Contract.

B. If the Employee/Member does not notify the Group, and the Group does not notify CareFirst, and it is later determined that a Dependent was not eligible for coverage, CareFirst has the right to recover the full value of the services and benefits provided during the period of ineligibility. CareFirst can recover these amounts from the Employee/Member or from the Dependent, at CareFirst's option.

4.4 Death of an Employee/Member. In the event of the Employee/Member's death, coverage of any Dependents will continue until the end of the month in which the Employee/Member died.

4.5 Reinstatement Requires Application. If coverage of any Member is cancelled or terminated for any reason, coverage may be renewed only if the individual reestablishes eligibility and submits an application in accordance with Section 2, Eligibility and Enrollment. Coverage will not reinstate automatically, under any circumstances.

4.6 Continuation of Coverage under COBRA. If the Group health benefit Plan provided under this Contract 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.

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

If an eligible employee leaves their job to perform military service, the eligible employee has the right to elect to continue their group coverage including any dependents for up to 24 months while in the military. Even if continuation of coverage was not elected during the eligible employee's military service, the eligible employee has the right to be reinstated in their group coverage when re-employed, without any waiting periods or pre-existing condition exclusions except for service connected illnesses or injuries. If an eligible employee has any questions regarding USERRA, the eligible employee should contact the Plan Administrator. The Plan Administrator determines eligible employees and provides that information to CareFirst.

4.8 Extension of Benefits for the Indemnity Program Option.

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

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

2. 12 months after the date coverage terminates.

Same Age Group means within the age group including persons three years older and younger than the age of the person claiming eligibility as Totally Disabled.

Substantial Gainful Activity means the undertaking of any significant physical or mental activity that is done (or intended) for pay or profit.

Totally Disabled (or Total Disability) means a condition of physical or mental incapacity of such severity that an individual, considering age, education, and work experience, cannot engage in any kind of Substantial Gainful Activity or engage in the normal activities as a person of the Same Age Group. A physical or mental incapacity is an incapacity that results from anatomical, physiological, or psychological abnormality or condition, which is demonstrable by medically accepted clinical and laboratory diagnostic techniques. CareFirst reserves the right to determine whether a Member is and continues to be Totally Disabled.

B. If a Member is confined in a Hospital on the date that the Member's coverage terminates, CareFirst shall continue to pay covered benefits, in accordance with the Contract in effect at the time the Member's coverage terminates, for the confinement until the earlier of:

1. The date the Member is discharged from the Hospital; or

2. 12 months after the date coverage terminates.

If the Member is Totally Disabled upon his/her discharge from the Hospital, the extension of benefits described in paragraph A., above applies; however, an additional 12-month extension of benefits is not provided. An individual is entitled to only one 12-month extension, not an inpatient 12-month extension and an additional Totally Disabled 12-month extension.

C. This section does not apply if:

1. Coverage is terminated because an individual fails to pay a required premium;

2. Coverage is terminated for fraud or material misrepresentation by the individual.

SECTION 5
MULTIPLE COVERAGE

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 Contract.

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 Contract.

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 set forth in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst Plan means this Contract.

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

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

The term Plan does not include:

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

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

3. Coverage regulated by a motor vehicle reparation law;

4. The first $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 are not living together:

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

c. Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired are 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.

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

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

2) Second, the benefits under the continuation coverage.

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

e. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered 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 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 Employer or Governmental Benefits
Coverage under this Contract 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.

5.3 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 Contract. Benefits that are covered by Medicare are subject to the provisions in this Part.

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

B. **Medicare as Primary**.

1. When benefits for Covered Services are paid by Medicare as primary, CareFirst will not duplicate those payments. When CareFirst coordinates the benefits with Medicare, CareFirst 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 CareFirst 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 his or her right to such benefits. Members shall agree to complete and submit to Medicare, CareFirst and/or Contracting

Providers all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

5.4 Personal Injury Protection ("PIP") Coverage.

PIP is insurance coverage without regard to fault provided under a Member's motor vehicle casualty insurance.

CareFirst will not reduce, limit, or exclude coverage due to payments made to the Member under the Member's PIP Policy.

5.5 Subrogation

Subrogation applies when a Member has an illness or injury for which a third party may be liable. Subrogation requires the Member in certain circumstances to assign to CareFirst any rights the Member may have against a third party.

A. The Member shall notify CareFirst as soon as reasonably possible and no later than the time the Member either submits a claim for damages to the third party, first or third party insurer or files suit, whichever first occurs, that a third party may be liable for the injuries or illnesses for which benefits are being paid.

B. To the extent that benefits are paid under this Contract, CareFirst shall be subrogated and succeed to any right of recovery of the Member against any person or organization.

C. The Member shall pay to CareFirst the amount recovered by suit, settlement, or otherwise from any third party or third party's insurer, or uninsured or underinsured motorist coverage, to the extent of the benefits paid under this Contract.

D. These provisions do not apply to residents of the Commonwealth of Virginia who are Members of a self-insured Group that is not subject to ERISA. A Member can ask his/her group administrator if he/she is a member of a self-insured Group that is not subject to ERISA.

SECTION 6
CLAIMS PROCEDURES

A. SCOPE AND PURPOSE

The Plan's Claims Procedures were developed in accordance with section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims For Benefits by Members (hereinafter referred to as Claimants). Except as otherwise specifically provided, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act. Additionally, because CareFirst must maintain uniformity in its processes, any group health plan not subject to ERISA agrees to follow these same procedures. Notwithstanding this provision, nothing herein shall be construed to mean or imply that a non-ERISA Group health plan has deemed itself subject to ERISA.

B. CLAIMS PROCEDURES

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

These Claims Procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant, provided that, in the case of a Claim Involving Urgent Care, a Health Care Professional, with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

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

C. CLAIMS PROCEDURES COMPLIANCE

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

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

a. Is a communication by a Claimant or an authorized representative of a Claimant that is received by the person or organizational unit designated by the Plan or Plan Designee that handles benefit matters; and

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

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

D. CLAIM FOR BENEFITS

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

E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

1. In general. Except as provided in item E.2., if a claim is wholly or partially denied, the Claimant shall be notified in accordance with item F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.

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

   a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Claimant shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claimant shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with item F. herein. The Claimant shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

      1) Receipt of the specified information, or

      2) The end of the period afforded the Claimant to provide the specified additional information.

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

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

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

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

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

2) Post-Service Claims. In the case of a Post-Service Claim, the Claimant shall be notified, in accordance with item F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

d. Calculating time periods. For purposes of item E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to item E.2.c. above due to a Claimant'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 Claimant until the date on which the Claimant responds to the request for additional information.

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

1. Except in the case of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, the Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of any Adverse Benefit Determination. The Notification shall set forth, in a manner calculated to be understood by the Claimant:

   a. The specific reason or reasons for the adverse determination;

   b. Reference to the specific Plan provisions on which the determination is based;

   c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

   d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of the Act following an Adverse Benefit Determination on review;

   e. In the case of an Adverse Benefit Determination:

      1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

      2) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

   f. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.

2. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, the information described above may be provided to the Claimant orally within the time frame prescribed in item E.2.a. herein, provided that a written or electronic Notification in accordance with item F.1. of this section is furnished to the Claimant not later than 3 days after the oral Notification.

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

1. To appeal a denied claim, a written request and any supporting record of medical documentation must be submitted to the address on the reverse side of your membership card within 180 days of the Adverse Benefit Determination.

2. a. A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the Claim For Benefits;

   b. A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim For Benefits;

   c. The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

3. In addition to the requirements of paragraphs G.2.a. through c. herein, the following apply:

   a. The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

   b. In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/ Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

   c. Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

   d. Health Care Professionals engaged for purposes of a consultation under item G.3.b. herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor subordinates of any such individuals; and

   e. In the case of a Claim Involving Urgent Care, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and the Plan or the Plan's Designee shall transmit within 72 hours of receipt of the expedited request for appeal its benefit determination. The determination may be made by telephone, facsimile, or other available similarly expeditious method.

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

1. In general. Except as provided in item H.2., a Claimant shall be Notified in accordance with item I. herein of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review, unless it is determined that special circumstances require an extension of time for processing the

claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or the Plan's Designee expects to render the determination on review.

2. The Plan or the Plan's Designee shall notify a Claimant of its benefit determination on review in accordance with the following, as appropriate.

   a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Claimant shall be Notified, in accordance with item I. herein, of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination.

   b. Pre-service claims. In the case of a Pre-Service Claim, the Claimant shall be Notified, in accordance with item I. herein, of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such Notification shall be provided not later than 30 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.

   c. Post-service claims. In the case of a Post-Service Claim, the Claimant shall be Notified, in accordance with item I. herein, of the benefit determination on review within a reasonable period of time. Such Notification shall be provided not later than 60 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.

3. Calculating time periods. For purposes of item H. herein, the period of time within which a benefit determination on review shall be made begins at the time an appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to item I.1. herein due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

4. In the case of an Adverse Benefit Determination on review, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in items I.3., I.4., and I.5. herein as is appropriate.

I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION OF APPEAL

The Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of its benefit determination on review. In the case of an Adverse Benefit Determination, the Notification shall set forth, in a manner calculated to be understood by the Claimant:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provisions on which the benefit determination is based;

3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim For Benefits;

4. A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under section 502(a) of the Act; and

5. a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

   b. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

   c. Other information may be available regarding dispute resolutions through your local U.S. Department of Labor Office and or your State insurance regulatory agency.

J. DEFINITIONS

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

1. Claim Involving Urgent Care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

   a. Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or,

   b. In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

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

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

4. Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant’s eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate.

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

6. Group Health Plan means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides "medical care" within the meaning of section 733(a) of the Act.

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

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

   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;

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

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

9. Plan means that portion of the Group Health Plan established by the Sponsor that provides for health care benefits for which CareFirst is the claims administrator under this Contract.

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

SECTION 7
GENERAL PROVISIONS

7.1 No Assignment. A Member cannot assign any benefits or payments due under the Contract to any person, corporation or other organization, except as required by law.

7.2 Payments Under the Contract. Payments for covered services will be made by CareFirst directly to Participating Providers. If a Member receives covered services from Non-Participating Providers, CareFirst reserves the right to pay either the Member or the provider and such payment shall, in either case, constitute full and complete satisfaction of CareFirst's obligation.

7.3 Claim Payments Made in Error. The Member is liable for any amount paid to a Member by CareFirst by mistake or in error on behalf of a Member.

7.4 Time Period for Filing Claims. All claims for covered services and supplies rendered by non-participating providers must be submitted to CareFirst or its designee within the timely filing periods that are listed below.

A. Medical Claims – fifteen (15) months after the date the services were rendered or supplies were received.

B. Prescription Drug Claims – twelve (12) months after the date the Prescription Drug was dispensed or supplies were received.

A Member's 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 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 Contract. 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 claim. CareFirst provides forms for this purpose.

7.5 Notice of Claim. A Member may request a claim form by writing or calling CareFirst. CareFirst does not require written notice of a claim.

7.6 Claim Forms. CareFirst provides claim forms for filing proof of loss.

7.7 Member Statements. Except in the instance of fraud, all statements made by Members shall be considered representations and not warranties and no such statement shall be the basis for avoiding coverage or denying a claim after coverage has been in force for two years from its Effective Date, unless the statement was material to the risk and was contained in a written application.

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

A. Possession of an identification card confers no right to benefits under the Contract.

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

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

7.9 Member Medical Records. It may be necessary to obtain Member medical records and information from Hospitals, skilled nursing facilities, physicians or other practitioners who treat the Member. When a Member becomes covered under the Contract, the Member (and if the Member is

legally incapable of giving such consent, the representative of such Member) automatically gives CareFirst permission to obtain and use such records and information, including medical records and information requested to assist CareFirst in determining benefits and eligibility of Members.

7.10 Privacy Statement. 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 plan sponsor named herein or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.

7.11 CareFirst's Relationship to the Group. The Group is not an agent or representative of CareFirst and is not liable for any acts or omissions by CareFirst or any Participating Provider. CareFirst is not an agent or representative of the Group and is not liable for any act or omission of the Group.

7.12 Administration of the Contract. CareFirst may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Contract.

7.13 Rights under Federal Law. The Contract 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"). The Group is the "Plan Administrator" for the purposes of ERISA and/or COBRA. As the Plan Administrator, it is the Group's responsibility to provide the Member with certain information, including access to, and copies of, plan documents describing 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." Under HIPAA, Certificates of Creditable Coverage will be provided by CareFirst. In any event, the Member should check with the Group to determine their rights under ERISA, COBRA, and/or HIPAA, as applicable.

7.14 Rules for Determining Dates and Times. The following rules will be used when determining dates and times under the Contract:

A. All dates and times of day will be based on Eastern Standard Time or Eastern Daylight Saving Time, as applicable.

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

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

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

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

7.15 Notices to the Subscriber. Notices to Subscribers required under the Contract shall be in writing directed to the Subscriber's last known address. It is the Group's responsibility to notify CareFirst of a Subscriber address change. The notice will be effective on the date mailed, whether or not the Subscriber receives the notice or there is a delay in receiving the notice.

7.16 Contract Binding on Members. The Contract can be amended, modified or terminated in accordance with any provision of the Contract or by mutual agreement between CareFirst and the Group. This does not require the consent or concurrence of Members. By electing coverage under the Contract, or accepting benefits under the Contract, each Member agrees (and if the Member is legally incapable of contracting, the representative of such Member agrees) to all the terms, conditions and provisions of the Contract.

7.17 Provider and Services Information. Listings of current In-Network Providers will be made available to Member's at the time of enrollment. Updated listings are available upon request.

7.18 Events outside of CareFirst's Control. An event outside of the control of CareFirst refers to a natural disaster, epidemic, complete or partial destruction of facilities, disability of a significant part of CareFirst staff, war (whether declared or not), riot, civil insurrection or any similar event over which CareFirst cannot exercise influence or control.

7.19 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 a Member's coverage under this Contract ceases before the Member'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 Member's coverage under the Group, to provide a certificate that reflects the period of coverage under this Contract.

B. Members 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 a Member entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the Member 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 Members When Coverage Ceases

In the case of a Member who is not a qualified beneficiary entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the Member ceases to be covered under this 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 a Member's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease on the earliest date that a claim is denied due to the operation of the lifetime limit.

c. Qualified Beneficiaries When COBRA Ceases

In the case of a Member who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the Member became entitled to elect COBRA continuation coverage), CareFirst will provide the certificate at the time the Member'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 Member 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, a Member at any time while the Member is covered under this Contract and up to 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 Member has previously received a certificate under paragraph B.1.b., paragraph 2 or 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 Member. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each Member and separately states the information that is not identical.

SECTION 8
CONVERSION PRIVILEGE

8.1 Conversion Privilege. A Member who has been continuously covered for at least three (3) months under the Group Contract and any group policy providing similar benefits which it replaces shall be eligible for a Conversion Contract without evidence of insurability. **Conversion Contract** means a non-Group health benefits contract issued in accordance with state law to individuals whose coverage under the Group Contract has terminated.

A. Notification

1. If a Member is entitled to continue coverage through a Conversion Contract, CareFirst will notify the Member of the conversion option on or before the date of termination of coverage, but not more than sixty-one (61) days before.

2. A Member who receives the timely notice of the conversion privilege shall be given the right to apply for a Conversion Contract up to forty-five (45) days after the date of the Member's termination under the Group Contract.

3. However, if CareFirst does not notify the Member of this conversion privilege or there is a delay in giving this notice, then the Member shall have at least thirty-one (31) days after the date of the notice in which to apply for a Conversion Contract, except that the time period within which a Member can elect to convert will not extend beyond ninety (90) days following the Member's termination date under the Group Contract.

4. Written notice presented to the Member or mailed by the Group to the last known address of the Member or mailed by CareFirst to the last known address of the Member as furnished by the Group shall constitute notice. Notice by mail which is returned undelivered does not constitute notice.

5. Conversion coverage is effective on the day following the date the Group Contract terminated or the Member's coverage under this Contract terminates and none of the exceptions below apply.

6. Benefits under a Conversion Contract may vary from the benefits under this Contract and CareFirst reserves all rights, subject to applicable requirements of law, to determine the form and terms of the Conversion Contract 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/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 legal annulment, 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, then 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

CareFirst will not issue a Conversion Contract if:

1. 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. The Member is eligible for Medicare;

3. Termination under the Group Contract occurred because:

   a. The Member performed an act or practice that constitutes fraud in connection with the coverage;

   b. The Member made an intentional misrepresentation of a material fact under the terms of coverage;

   c. The terminated coverage under the Group Contract was replaced by similar coverage within thirty-one (31) days after the date of termination of the Group Contract; or,

   d. The Member failed to pay a required premium.

4. The application shows the Member is covered under a group policy providing benefits substantially similar to the maximum benefits which the Member could elect under the Conversion Contract, or if the Member has other health benefits available at least equal to the level of benefits which would permit CareFirst to refuse to renew a Conversion Contract.

5. The Member 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.

6. The Member is covered for similar benefits under any arrangement of coverage for individuals in a group or in the military, on an insured or uninsured basis.

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

8. CareFirst will not issue a Conversion Contract if benefits provided or available to the Member under items 5, 6, and 7, above, together with the Conversion Contract, would result in overinsurance according to CareFirst's standards on file with the Maryland Insurance Administration.

D. Application

CareFirst must receive the Member's application form, including full payment of the applicable premium, within forty-five (45) days after the effective date of termination, or within forty-five (45) days following CareFirst's notice, whichever is later.

ATTACHMENT C
DESCRIPTION OF COVERED SERVICES
FOR MEMBERS ENROLLED IN THE MEDICARE CARVE-OUT PROGRAM

MEDICARE CARVE-OUT PLAN

Individuals who were hired by the County prior to January 1987 and who elected to retain the Medicare Carve-Out Plan in effect on December 31, 1986, as retirees, will have their medical expense benefits described in this ATTACHMENT C. Those benefits are only payable to the extent medical expenses are in any way not reimbursable through any public program including Medicare. Anyone eligible for both Part A and Part B of Medicare will be considered to be covered under both Part A and Part B of Medicare. Anyone eligible for Part B only will be considered to be covered under Part B only.

This Attachment C describes the medical services eligible for coverage under the Medicare Carve-Out Program. The amount that the Carve-Out Program pays for these covered services is in Section 11. Section 11 also lists important information about Member deductibles, a Member's Out-of-Pocket Limit and other features that affect the cost of coverage.

SECTION 1
GENERAL PROVISIONS

1.1 Overview of Cost Sharing and Maximum Amounts. This section summarizes the basic rules governing for what a Member pays and what the Program pays for Covered Services. Detailed information about these payment features can be found in the Schedule of Benefits, including specific terms and amounts and any special exceptions.

Deductible:	For most Covered Services, the Program does not begin to pay benefits until a Member meets his or her deductible for that year. The deductible will be calculated on a calendar year basis. Until the deductible is satisfied, when a Member receives services subject to the deductible he or she must pay for them directly. Once a Member has satisfied the deductible, the Program will pay for Covered Services, less coinsurance, and Copayments. The Schedule of Benefits provides additional information about the deductible(s), including the amount of the deductible(s), how the deductible(s) apply to In-Network and Out-of-Network services and a listing of the services that are subject to the deductible(s). Common Accident Deductible When two or more family Members incur Covered Services due to the same accident, only one individual Deductible amount will be applied in a Benefit Period. Deductible Carryover Provision If the Member has Deductible expenses in the last three (3) months of one (1) calendar year he may be able to apply these expenses toward meeting his Deductible for the following year. The Member can apply these expenses to his next year's Deductible if the expenses apply to services that are subject to the Deductible and the Member did not exceed his Deductible in the prior year.
Coinsurance	Once the deductible is met (or for services that are not subject to the deductible), benefits are based on a sharing of costs between the Member and the Program. For most Covered Services, these costs are shared based on the percentage of the cost that the Program pays and the percentage that the Member must pay. These percentages are referred to as the coinsurance.
Copayment	A Copayment is similar to coinsurance, except that Copayments are set as a fixed dollar amount, rather than as a percentage of expenses.
Annual Out-of-Pocket Limit	This feature limits the maximum amount that a Member will have to pay in coinsurance in any given year. Once a Member meets the annual Out-of-Pocket Limit, he or she will no longer be required to pay a share of the coinsurance for the remainder of that year.
Lifetime Maximum	There is a cap on the total benefits that the Program will pay on behalf of any individual Member.

1.2 Benefit Terms Defined. In addition to the previously defined terms, this Attachment uses certain other defined terms. These are generally defined in the Section in which they first appear. The following general terms are also used:

Allowed Benefit means:

For a Participating Provider, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. 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.

For a Non-Participating Practitioner, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit for a Participating 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.

For a Non-Participating Facility, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or the established Allowed Benefit if one has been established for that type of Eligible Provider and service. 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 as stated above, 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 claim from the Non-Participating 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 administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period for this Attachment C is on a calendar year basis.

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.

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 Attachment C.

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

Health Care Facility means a Hospital, ambulatory surgical facility or center, inpatient rehabilitation facility, home health agency, 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 Contract, 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 Hospital, Health Care Facility, or Health Care Practitioner licensed or otherwise authorized by law to provide Covered Services.

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

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.

Participating Provider means an Eligible Provider that contracts with CareFirst to be paid directly for rendering Covered Services to eligible Members of this Program.

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/her prior skill and functional level.

1.7 Limitation on Provider Coverage. Services are covered only if the provider is an Eligible Provider as defined above, is licensed in the jurisdiction in which the services are rendered and if the services are within the lawful scope of the services for which that provider is licensed. Coverage does not include services rendered to a Member by any individual who:

A. is not an Eligible Provider;

B. is the Member's spouse, Domestic Partner, mother, father, grandparent, daughter, son, brother, or sister; or

C. resides in the Member's home.

1.8 Out-of-Area Care.

A. Definitions

Host Blue means an on-site Blue Cross and/or Blue Shield Licensee providing benefits for Covered Services to the Member outside of CareFirst's local Service Area(s).

Service Area means the geographic area(s) CareFirst serves.

B. BlueCard Program

Like all Blue Cross and Blue Shield Licensees, CareFirst participates in a program called "BlueCard."

BlueCard, and BlueCard PPO, if applicable, enable Members to access Host Blues networks of contracted providers for services rendered outside the Service Area.

To receive the maximum amount of coverage available, Members are responsible for ensuring out-of-area care is rendered by a Host Blue's contracted providers. Whenever Members access health care services outside the Service Area, the claim for those services may be processed through BlueCard and presented to CareFirst for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Members receive covered health care services within the geographic area served by a Host Blue, CareFirst will remain responsible to the Group/Sponsor for fulfilling CareFirst's Group Contract obligations. The Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its providers and handling all interaction with its contracted providers.

The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim

The calculation of Group/Sponsor liability on claims for covered health care services incurred outside the Service Area and processed through BlueCard will be based on the negotiated price CareFirst pays the Host Blue.

The calculation of Member liability on claims for covered health care services incurred outside the Service Area and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price CareFirst pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's provider contracts. The negotiated price paid to a Host Blue by CareFirst on a claim for services processed through BlueCard may represent:

1. The actual price paid on the claim by the Host Blue to the health care provider ("Actual Price"), or

2. An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care providers or one or more particular providers ("Estimated Price"), or

3. An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers ("Average Price"). An Average Price may result in greater variation to the Member and the Group/Sponsor from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Member and the Group/Sponsor is a final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of Estimated Price or Average Price may result in some portion of the amount paid by the Group/Sponsor being held in a variance account by the Host Blue, pending settlement with its participating Health Care Providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to the Group/Sponsor and are eventually exhausted by Health Care Provider settlements and through prospective adjustments to the negotiated prices.

Statutes in a small number of states may require a Host Blue either:

1. To use a basis for calculating the Member liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim, or

2. To add a surcharge.

Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst would then calculate the Member and the Group/Sponsor liability for any BlueCard-eligible covered

service in accordance with the applicable statute for the state or area where the Host Blue conducts business in effect at the time the Member received those services. However, when this payment methodology results in a conflict of statutes or regulations between two states, CareFirst will comply with the statutes of the jurisdiction in which the Group/Sponsor's Contract was issued.

Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from participating providers of a Host Blue can arise in several ways, including but not limited to anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third-party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require either correction on a claim-by-claim basis or on a prospective basis through an allocated reduction on future claims where recoveries cannot be linked to specific claims.

CareFirst will arrange to share such recoveries proportionately with the Group/Sponsor and Members in accordance with the terms and conditions of the Group/Sponsor's Contract.

Utilization Management Requirements and BlueCard

The Utilization Management Requirements of the Contract, if any, shall apply to BlueCard. The Member is responsible for:

1. Ensuring all Utilization Management Requirements are followed;

2. Any penalties for not complying with such requirements; and, or

3. Charges for services CareFirst deems Not Medically Necessary; and/or not covered under the Contract.

However, there may be instances where BlueCard claims are subject to the Host Blue's utilization management requirements and/or provider network rules, which may vary slightly from those stated in the Contract. Such variances may result from state laws that differ from those in the jurisdiction in which the Group/Sponsor's Contract was issued or from contracts the Host Blue holds with its vendors/providers.

While CareFirst strives to provide consistent benefits for all Members, a Host Blue's utilization management requirements/vendors and provider network rules may sometimes affect a Member's benefits. Members accessing health care services outside the Service Area should call 800-810-BLUE (2583) for that Host Blue's utilization management requirements/provider network rules prior to receiving services.

BlueCard Fees and Compensation

The Group/Sponsor understands and agrees:

1. To pay certain fees and compensation to CareFirst which CareFirst is obligated under BlueCard to pay to the Host Blue, to the Blue Cross and Blue Shield Association, or to BlueCard vendors, unless CareFirst's contractual obligations with the Group/Sponsor require those fees and compensation to be paid only by CareFirst; and

2. That fees and compensation under BlueCard may be revised from time to time without the Group/Sponsor's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard.

CareFirst will charge these fees using the following arrangement: The BlueCard access fee will be charged separately each time a claim is processed through BlueCard and is included in Paid Claims. The BlueCard access fee charged will not exceed the current rate permitted under current BlueCard Program Policy, and it will also not exceed $2,000 for any claim. All other BlueCard-related fees – such as the administrative expense allowance (AEA), Central Financial Agency Fees, ITS Transaction Fees, a toll-free number fee and a fee for providing PPO provider directories, if applicable – are included in the Administrative Fee.

BlueCard Eligibility Claim Types

All claim types are eligible to be processed through the BlueCard Program except for those Dental Care Benefits, Prescription Drug Benefits, or Vision Care Benefits that may be delivered by a third-party contracted by CareFirst to provide the specific service or services.

C. CareFirst's Payment and Member Responsibilities for Services Rendered by Non-Contracted Providers Outside the Service Area

1. CareFirst's payment for Covered Services rendered by non-contracted providers outside the Service Area.

   CareFirst's payment for Covered Services rendered by a non-contracted provider outside of CareFirst's Service Area is generally determined by the Host Blue. In most instances, the amount the Host Blue allows for the Covered Services is deemed CareFirst's "Allowed Benefit" regardless of whether the amount the Host Blue allows is greater or lesser than CareFirst's Allowed Benefit and is deemed a final amount. Exceptions to this are limited to the following situations:

   a. If the Host Blue does not have an allowed amount for the Covered Services, CareFirst's Allowed Benefit is used and is deemed a final amount.

   b. If the Group Contract benefits allow, CareFirst may pay up to billed charges for Emergency or Urgent Care services when no accessible contracted provider is available; and

   c. CareFirst may, with the consent of the Host Blue, apply a negotiated rate in a case management situation.

2. a. Member responsibilities for Covered Services rendered by non-contracted providers outside the Service Area.

      For Covered Services rendered by non-contracted providers outside the Service Area, the Member is responsible for:

      1) Ensuring all Utilization Management Requirements are followed;

      2) Any penalties for not complying with such requirements;

      3) Any applicable Member payment amounts, as stated in the Schedule of Benefits, and for:

a) The difference between the Host Blue's Allowed Benefit and the non-contracted provider's billed charges; or

b) If the Host Blue does not have an allowed amount for the Covered Services, and CareFirst's Allowed Benefit is used, the difference between CareFirst's Allowed Benefit and the non-contracted provider's billed charges.

b. Member responsibilities for Not Medically Necessary and/or non-covered services rendered by non-contracted providers outside the Service Area.

The Member is responsible for billed charges for care rendered by non-contracted providers outside the Service Area that is deemed Not Medically Necessary and/or not covered under the Contract.

SECTION 2
UTILIZATION MANAGEMENT REQUIREMENTS

IMPORTANT

FAILURE TO MEET THE REQUIREMENTS OF THE UTILIZATION MANAGEMENT PROGRAM MAY RESULT IN A REDUCTION OR DENIAL OF COVERAGE EVEN IF THE SERVICES ARE MEDICALLY NECESSARY.

Prior authorization is not required for services covered by Medicare.

2.1 Utilization Management. Before certain services will be covered (See Section 2.5), they will be subject to review and approval under Utilization Management Requirements established by the Program. Through Utilization Management, CareFirst reviews a Member's care and evaluates requests for approval of coverage to assess the Medical Necessity for the services, the appropriateness of the Hospital or facility requested, and the appropriate length of confinement or course of treatment. This assessment will be made in accordance with established criteria. In addition, Utilization Management may include second surgical opinion and/or pre-admission testing requirements, concurrent review, discharge planning and Case Management. Failure or refusals 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. The effect on coverage for failure to comply with Utilization Management Requirements is explained in the Schedule of Benefits. If coverage is reduced or denied for failure to comply with Utilization Management Requirements, the reduction or exclusion will be applied to all services related to the treatment, admission, or portion of the admission for which Utilization Management Requirements were not met.

2.2 Member Responsibility. Except as provided in Section 2.2, Members are responsible for all Utilization Management Requirements. It is the Member's responsibility to assure that Hospitals, physicians, and other providers associated with the Member's care cooperate with Utilization Management Requirements. This includes initial notification in a timely manner, responding to CareFirst's inquiries and, if requested, allowing CareFirst representatives to review medical records on-site or in its offices. If CareFirst is unable to conduct utilization reviews, benefits may be reduced or denied.

2.3 Procedures. To initiate Utilization Management review, a Member may directly contact CareFirst or may arrange to have notification given by a family member or by the physician, provider, or facility that is involved in the Member's care. 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 if they provide inaccurate or incomplete information, the Member will be responsible for any reduction or exclusion of benefits.

CareFirst will provide additional information regarding Utilization Management Requirements and procedures, including telephone numbers and hours of operation, at the time of enrollment or at any time upon the Member's request. For questions regarding Utilization Management Requirements, call the toll-free number for pre-certification on the back of the Member's identification card.

2.4 Services Subject to Utilization Management. Except as provided in Section 2.2,the Member must satisfy the Utilization Management Requirements to qualify for coverage for the following services:

A. **Hospital Inpatient Services**. All hospitalizations (excluding maternity) require pre-certification. A Member must contact CareFirst (or have his physician or the Hospital 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 medically feasible to delay the admission for five (5) business days due to a medical condition, CareFirst must receive notification of the admission as soon as possible but, in any event, within 48 hours following the beginning of the admission, or the end of the first business day following the beginning of the admission, whichever is earlier.

B. **Inpatient Mental Health and Substance Abuse Services**. All hospitalizations for Mental Health and Substance Abuse services require pre-certification. A Member must contact CareFirst or its designee (or have his physician or the Hospital contact CareFirst or its designee) 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 medically feasible to delay the admission for five (5) business days due to a medical condition, CareFirst must receive notification of the admission as soon as possible but, in any event, within 48 hours following the beginning of the admission, or the end of the first business day following the beginning of the admission, whichever is later.

C. **Outpatient Mental Health and Substance Abuse Services**. CareFirst or its designee will review and evaluate claims for Outpatient Mental Health and Substance Abuse services to assess the medical necessity and appropriateness of the services. 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.

D. **Other Services**. If a Member requires any of the following services, the Member must contact CareFirst (or have the Member's 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 Care Services;
2. Skilled Nursing Facility Services;
3. Hospice Care Services;
4. Outpatient Private Duty Nursing;
5. General Anesthesia for Dental Care;
6. Infertility Services.
   - Artificial Insemination (AI);
   - Intrauterine Insemination (IUI);
   - Assisted Reproductive Technology, including:
     *In Vitro Fertilization (IVF);
     *Gamete Intrafallopian Transfer (GIFT);
     *Zygote Intrafallopian Transfer (ZIFT).

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 the Group or Member of such changes.

2.6 Concurrent Review and Discharge Planning. Following timely notification as described above, 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 approved treatment.

2.7 Case Management. This is a feature of this health benefit plan for a Member with a chronic condition, a 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 and 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.

2.8 Appealing a Utilization Management Decision. If a Member or Member's provider disagrees with a Utilization Management decision, the decision will be reviewed upon request. If necessary, the Medical Director or Associate Medical Director will discuss the Member's case with the Member's physician. Any non-certification or penalty may be appealed. Refer to Section 6, Claims Procedures, of the Program Description.

SECTION 3
PHYSICIAN AND PROVIDER SERVICES

3.1 Preventive Services. Coverage will be provided for the following preventive services.

A. The following Child Wellness services:

1. All visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control;

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

3. All 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;

The following services at each of the visits described above:

a. A physical examination;
b. A developmental assessment;
c. Parental anticipatory guidance;
d. Laboratory tests considered necessary by the physician as indicated by the services provided as described above.

B. Adult preventive physical examinations including examination, laboratory tests, and vaccinations, provided these services are not required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

C. Pap smears, at intervals appropriate to the Member's age and health status.

D. Mammography services, at intervals described in the Schedule of Benefits.

E. Colorectal Cancer Screening. Benefits are available for a 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.

F. Prostate cancer screening – benefits are available for medically recognized diagnostic examinations that shall include a digital rectal examination and a Prostate Specific Antigen (PSA) test.

G. Other preventive services, if any, stated in the Schedule of Benefits.

H. Chlamydia and Human Papillomavirus Screening.

1. Definitions

Chlamydia Screening Test means any laboratory test that specifically detects for infection by one or more agents of *Chlamydia trachomatis* and is approved for this purpose by the FDA.

Human Papillomavirus Screening Test means any laboratory test that specifically detects for infection by one or more agents of the human papillomavirus and is approved for this purpose by the FDA.

Multiple Risk Factors means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

2. Covered Services. An annual routine Chlamydia Screening Test for:

   a. Female Members who are under the age of 20 years if they are sexually active; and at least 20 years old if they have Multiple Risk Factors.

   b. Male Members who have Multiple Risk Factors.

   c. A Human Papillomavirus Screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.

I. Osteoporosis Prevention and Treatment Services.

1. Benefits are available for Bone Mass Measurement for the prevention, diagnosis, and treatment of Osteoporosis when the Bone Mass Measurement is requested by a Health Care Provider for the Qualified Individual.

2. Bone Mass Measurement means a radiologic or radioisotopic procedure or other scientifically proven technology performed on a Qualified Individual for the purpose of identifying bone mass or detecting bone loss.

3. Qualified Individual means:

   a. An estrogen deficient individual at clinical risk for osteoporosis;

   b. An individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;

   c. An individual receiving long-term glucocorticoid steroid therapy;

   d. An individual with primary hyperparathyroidism; or

   e. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

3.2 Diagnostic and Treatment Services. Coverage will be provided for diagnostic and treatment services by a physician or other Health Care Practitioner. Coverage includes the following services in a medical office, facility or as a Hospital outpatient:

A. Office visits, including care and consultation by physicians and specialists. Coverage does not include charges for telephone consultations, failure to keep a scheduled visit, or completion of any form;

B. Diagnostic procedures, laboratory tests and x-ray services, including:
   1. electrocardiogram, electroencephalogram; tonography;
   2. laboratory services;
   3. diagnostic x-ray services, diagnostic ultrasound services;

C. Treatment and therapeutic services in connection with a covered procedure, including:
   1. chemotherapy (benefits for high dose chemotherapy are limited to that as described in Section 3.12);

2. electroshock therapy;
3. radiation therapy;
4. radioisotope services.

D. Allergy tests, injections and serum;

E. Speech therapy, occupational therapy or physical therapy. Coverage does not include maintenance therapy for a chronic disease or condition or nonmedical ancillary services such as vocational rehabilitation, employment counseling, educational therapy, or Habilitatitive Services.

Definitions.

1. **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.

2. **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.

3. **Physical Therapy (PT)** means 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.

F. Habilitative Services. Occupational Therapy, Physical Therapy and Speech Therapy for the treatment of a Dependent child under the age of 19 years with a congenital or genetic birth defect that enhance the Dependent 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.

G. Services in connection with covered Hospital Emergency Room Services (see Section 4.4);

H. Spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.

3.3 Maternity and Related Services. The following services will be covered if a Member is eligible. Benefits are provided for all female Members.

A. Obstetrical care for a normal pregnancy, an ectopic pregnancy, miscarriage or complications of pregnancy is covered for all female Employee/Member(s), a spouse and dependent children for maternity coverage. When applicable, coverage includes cesarean section if medically indicated, or delivery, including prenatal care and postnatal care.

Following childbirth, coverage will be provided for a minimum Hospital stay of not less than 48 hours following an uncomplicated vaginal delivery, or 96 hours following an uncomplicated cesarean section.

B. If the delivery occurs in the Hospital the length of stay begins at the time of the delivery. If the delivery occurs outside of the Hospital the length of stay begins upon admission to the Hospital. The Member and provider may agree to an early discharge. Prior authorization is not required.

C. Routine newborn care is included while the mother is hospitalized for covered maternity care, provided the mother is a Member and eligible for maternity benefits. The mother may request that the newborn also remain in the Hospital for up to 4 days. Coverage is limited to routine newborn visits (not to exceed two visits) male circumcision, and up to two (2) well baby post-partum visits. To qualify for coverage of other services, the newborn must be a Member in his or her own right.

D. Medically Necessary services for the normal newborn (an infant born at approximately 40 weeks gestation who has no congenital or comorbid conditions including but not limited to neonatal jaundice) including the admission history and physical, and discharge examination;

E. Post-partum visits for home care of the mother and newborn child following discharge hospitalization for childbirth, as may be prescribed by the attending provider. Home visits will:

1. Be covered without Copayments, Coinsurance amounts or Deductibles required under the Contract;

2. Be provided in accordance with generally accepted standards of nursing practice for home care of the mother and newborn child;

3. 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

4. Include any services required by the attending provider.

When CareFirst is notified of the Member's pregnancy, CareFirst will provide the Member with information prior to the delivery date on post-partum home visits for the mother and child, including the names of providers that are available for post-partum home visits.

F. Medically Necessary inpatient/outpatient Health Care Provider services for a newborn with congenital or comorbid conditions;

G. Infertility Services
Benefits are provided for infertility services including artificial insemination and in-vitro fertilization, when the Member is married or in a Domestic Partnership.

1. Benefits are limited to:

a. Infertility counseling;

b. Testing;

c. Assisted reproductive technologies as described and limited below.

Artificial insemination.

1. Benefits are available when:

    a. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of at least 1 year of unprotected vaginal intercourse following the reversal of an elective sterilization procedure in order for artificial insemination to be covered.

    b. The Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination; and

    c. The treatment is pre-authorized by CareFirst.

2. Any charges associated with the collection of sperm will not be covered unless the male donor is also a Member.

3. The Member is responsible for the copayment as stated in the Schedule of Benefits.

In-vitro fertilization (IVF).

1. Benefits (including zygote and gamete intra-fallopian transfer) are provided for outpatient expense arising from IVF procedures approved by the federal Food and Drug Administration that are performed at medical facilities that conform to:

    a. The American College of Obstetricians and Gynecologists guidelines for IVF clinics; or,

    b. The American Society for Reproductive Medicine minimal standards for IVF programs.

2. Benefits are available when:

    a. The treatment is pre-authorized by CareFirst;

    b. The oocytes (eggs) are physically produced by the Member and fertilized with sperm;

    c. The Member has been unsuccessful through less costly infertility treatment for which coverage is available; and

    d. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of infertility of at least 2 years' duration; or, the infertility is associated with any of the following medical conditions:

        1) Endometriosis;

        2) Exposure in utero to diethylstilbestrol, commonly known as DES.

        3) Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); however, if blockage is due to an elective sterilization procedure, the Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must also have a history of infertility of at least 2 years' duration following the reversal of

an elective sterilization procedure.

4) Abnormal male factors, including oligospermia, contributing to the infertility.

3. Benefits, are limited to:

a. A lifetime maximum payment as stated in the Schedule of Benefits.

b. Three attempts per live birth.

The lifetime maximum and benefit limits in no way create a right to benefits after termination of the Member's coverage under the evidence of coverage.

4. The Member will be responsible for the coinsurance as stated in the Schedule of Benefits.

When the Member has had a reversal of an elective male or female surgical sterilization procedure then:

1. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of infertility of at least 2 years' duration following the reversal of an elective sterilization procedure in order for IVF procedures to be covered.

2. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of at least 1 year of unprotected vaginal intercourse following the reversal of an elective sterilization procedure in order for artificial insemination to be covered.

Exclusions. Specific exclusions related to infertility services are listed with the Exclusions at the end of this Description Of Covered Services.

H. Elective Abortions.

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

J. Depo-Provera, Norplant, intra-uterine devices and any Medically Necessary insertion, removal, or examination associated with the use of any contraceptive drug or device that is approved by the FDA for use as a contraceptive.

3.4 Surgical Care (Inpatient and Outpatient). Coverage will be available for surgical procedures performed by Health Care Practitioners on an outpatient basis, or a covered inpatient Hospital admission for which benefits are being provided under Section 4, subject to the applicable Utilization Management requirements stated in Section 2.

A. Pre- and post-operative services are included in the Allowed Benefit. There are no separate benefits except as specified in this Contract.

B. If multiple surgical procedures are performed during the same operative session, CareFirst will review the procedures to determine the benefits provided:

1. if the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the Contract based on the Allowed Benefit for the primary surgical procedure. All other incidental,

integral to/included in, or mutually exclusive procedures are not eligible for benefits.

2. if the additional procedures are not clinically integral to the primary procedure, including, but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the Contract based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.

C. Surgery, including Oral Surgery Services, Section 3.10 E, limited to:

1. Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a Member condition, benefits will be based upon the lowest cost alternative.

3.5 Inpatient Medical Care. The following Inpatient Medical Care services are covered under the Program, but only if a Member is an inpatient in a Hospital and is otherwise covered under Section 4 for the very day on which the services are rendered to the Member.

A. Health Care Practitioner visits during the Hospital stay; one per day (additional if warranted by the complexity of the Member's condition);

B. Intensive care which requires a Health Care Practitioner's attendance;

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

D. Inpatient diagnostic and treatment services provided and billed by a physician or other Health Care Practitioner, including:

1. Diagnostic procedures, laboratory tests and x-ray services, including:
   a. electrocardiogram, electroencephalogram; tonography;
   b. laboratory services;
   c. diagnostic x-ray services, diagnostic ultrasound services;

2. Treatment and therapeutic services in connection with a covered procedure, including:
   a. chemotherapy (benefits for high dose chemotherapy are limited to that as stated in Section 3.12);
   b. electroshock therapy;
   c. radiation therapy;
   d. radioisotope services.
   e. physical therapy and inhalation therapy

The Health Care Practitioner services identified in this Section, including physician visits, charges for intensive care or consultative services, will be covered only if CareFirst determines that the Health Care Practitioner rendered the services to the Member and that such services were medically required to diagnose or treat the Member's condition.

3.6 Anesthesia Service. Coverage is 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. Coverage is also available for acupuncture when used as an anesthetic and for pain management when traditional methods were tried and failed.

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

3.8 Ambulance Services.

A. Medically Necessary air transportation and ground ambulance services, as determined by CareFirst.

B. **Foreign Transportation.** If the Member requires professional medical care for an injury or illness while traveling outside the United States, CareFirst or its authorized agent will cover the reasonable and necessary costs to transport the Member to a location where more appropriate medical care is available. Coverage includes air or ground ambulance services as Medically Necessary as determined by CareFirst.

3.9 Treatment for Cleft Lip and Cleft Palate. Benefits will be provided for inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological and speech/language treatment for cleft lip and cleft palate.

3.10 Dental Services and Oral Surgery Services.

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

1. The injury did not arise while or as a result of biting or chewing; and

2. 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.

Benefits are limited to 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.

B. General Anesthesia for Dental Care. Benefits for Medically Necessary general anesthesia in conjunction with dental care and associated Hospital or ambulatory facility charges will be provided to a Member when determined by a licensed dentist in consultation with the Member's treating physician to effectively and safely provide dental care:

1. If the Member is:

a. Seven years of age or younger;

b. Developmentally or otherwise severely disabled; and

c. For whom a successful result cannot be expected under local anesthesia because of the physical, intellectual or other medically compromising condition of the Member.

Or, if the Member is:

a. Seventeen years of age or younger;

b. An extremely uncooperative, fearful, or uncommunicative individual;

c. An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and

d. An individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

A determination of medical necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition requires general anesthesia and the admission to a Hospital or outpatient surgery facility in order to safely provide the dental care.

2. Benefits for general anesthesia and associated Hospital or ambulatory facility charges are restricted to dental care that is provided by:

   a. A fully accredited specialist in pediatric dentistry;

   b. A fully accredited specialist in oral and maxillofacial surgery; and

   c. A dentist to whom Hospital privileges have been granted.

3. Benefits for the general anesthesia and associated Hospital or ambulatory facility charges require prior authorization by CareFirst. The Member or provider of service must contact CareFirst prior to the date that services are rendered to obtain approval.

4. Benefits are not provided for general anesthesia and associated Hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.

5. Benefits for the underlying dental care are not covered.

C. Dental benefits, including orthodontic treatment, will be provided for treatment of cleft lip or cleft palate as described in Section 3.9.

D. Except as listed above, all other dental care is excluded from coverage. Benefits for oral surgery are described below:

E. **Oral Surgery Services**. Coverage will be provided for 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 are performed on sound natural teeth and supporting structures, lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, and jaws.

Medically Necessary procedures, as determined by CareFirst, needed as a result of an accidental injury, when the Member requests oral surgical services or the need for oral surgical services is identified in the patient's medical records within 60 days of the accident. Benefits for such oral surgical services shall be provided up to three (3) years from the date of injury.

Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness.

3.11 Organ/Tissue Transplants. Coverage for organ and tissue transplants is limited to the following procedures:

A. Benefits will be provided for Medically Necessary organ transplants that are performed for reasons that are not considered Experimental or Investigational, as determined by CareFirst.

B. Covered Services include the following:

1. The expenses related to registration at transplant facilities. The place of registry is subject to review and determination by CareFirst.

2. Organ procurement charges including harvesting, recovery, preservation, and transportation of the donated organ.

3. Cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of 18 years) to and from the site of the transplant.

4. There is no limit on the number of re-transplants that are covered.

5. If the Member is a recipient of a covered organ/tissue transplant, we will cover the Donor Services (as defined below) to the extent that the services are not covered under any other health insurance plan or contract. Donor Services consist of services covered under your Agreement or Contract 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 Attachment to this Contract.

All charges directly or indirectly relating to the transplantation of non-human organs are excluded. This exclusion will not be used to deny Medically Necessary, non-experimental skin grafts that are covered under the Contract.

3.12 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 or Investigational as determined by CareFirst.

3.13 Clinical Trials. Benefits for Patient Cost to a Member in a Clinical Trial will be provided in accordance with the terms below. All services must be pre-authorized or pre-approved by CareFirst.

A. Terms.

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:

1. The National Cancer Institute Clinical Cooperative Group;

2. The National Cancer Institute Community Clinical Oncology Program;

3. The Aids Clinical Trials Group; and,

4. The 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 service that is incurred as a result of the treatment being provided under the Clinical Trial. Patient Cost does not include:

1. The cost of an Experimental-Investigative drug or device;
2. The cost of non-health care services that a Member may be required to receive under the Clinical Trial; or
3. Costs associated with managing the research associated with the Clinical Trial; or
4. Costs that would not be covered under the Contract for non-Investigative treatments.

B. Patient Cost related to a Clinical Trial will be covered if the Member's participation in the Clinical Trial is the result of:

1. Treatment studies provided for a life-threatening condition; or

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

C. Coverage for Patient Cost for treatment being provided will be evaluated on a case-by-case basis. Coverage for Patient Cost 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 Clinical Trial for treatment, prevention and early detection of cancer; or

2. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for treatment, prevention and early detection of any other life threatening condition;

3. The treatment is being provided in a Clinical Trial approved by:
   a. One of the National Institutes of Health, such as the National Cancer Institute (NCI); or
   b. An NIH Cooperative Group or an NIH Center; or
   c. The FDA in the form of an Experimental-Investigative new drug application; or
   d. The federal Department of Veterans Affairs; or,
   e. 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;

4. The facility and personnel providing the treatment are capable of doing so by virtue of their:
   a. Experience;
   b. Training; and,
   c. Volume of patients treated to maintain expertise;

5. There is no clearly superior, non-Investigative treatment alternative; and,

6. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Investigative alternative.

D. Coverage is provided for 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.

3.14 Reconstructive Breast Surgery. Benefits will be provided for reconstructive breast surgery resulting from a Mastectomy performed as a result of breast cancer. Mastectomy means the surgical removal of all or part of a breast as a result of breast cancer.

A. Reconstructive Breast Surgery includes:

1. Augmentation mammoplasty;

2. Reduction mammoplasty; and

3. Mastopexy.

B. Benefits are provided for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive breast on the diseased breast is performed.

C. Benefits are provided regardless of whether the Mastectomy was performed while the Member was covered under this Contract.

D. Coverage will be provided for prostheses for a Member who has undergone a Mastectomy as well as services resulting from physical complications at all stages of Mastectomy including lymphedemas.

3.15 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.

3.16 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.

3.17 Outpatient Private Duty Nursing.

Outpatient Private Duty Nursing is defined as skilled care services, ordered by a physician, that can only be provided by a licensed health care professional who is a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), based on a treatment plan 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 care from an R.N. or an L.P.N. is not necessary. Skilled care excludes services for performing the Activities of Daily Living (ADL) including but not limited to bathing, feeding and toileting.

Conditions for Coverage:

A. The Outpatient Private Duty Nursing services must be Medically Necessary and meet the definition above;

B. The Outpatient Private Duty Nursing services must be preauthorized by CareFirst and be part of an approved treatment plan on file at CareFirst;

C. The Outpatient Private Duty Nursing services must be ordered by a physician.

3.18 Cardiac Rehabilitation.

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. 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.

3.19 Diabetes Self-Management Training. Coverage will be provided for diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician, or other appropriately licensed health care provider, to be necessary for the treatment of diabetes (Types I and II) or elevated blood glucose levels induced by pregnancy.

If deemed necessary, the diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through a program supervised by an appropriately licensed, registered or certified health care provider whose scope of practice includes diabetes education or management.

3.20 Coverage for Prosthesis after Mastectomy. Coverage will be provided for a prosthesis that has been prescribed by a physician for a Member who has undergone a Mastectomy and has not had breast reconstruction.

3.21 Follow-up Home Care after 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 a outpatient basis, coverage shall be provided for:

A. One home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and

B. An additional home visit if prescribed by the Member's attending physician.

3.22 Prescription Drugs. Benefits are available for drugs or medicines that require a written prescription by federal law; and are dispensed by a licensed pharmacist or Health Care Practitioner. Benefits include coverage for:

A. Any contraceptive drug or device approved by the United States Food and Drug Administration for use as a contraceptive and obtained under a prescription written by an authorized prescriber, and

B. The insertion or removal, and any medically necessary examination associated with the use, of such contraceptive drug ort device.

3.23 Supplemental Accident Benefits. Supplemental Accident Benefits are available for covered services and/or supplies rendered to a Member as a result of an accidental injury that occurred

after the Member's effective date of coverage under this Carve-Out Program. The Carve-Out Program will pay Supplemental Accident Benefits after it has made its payment for the initial treatment received within 48 hours of the accidental injury. Supplemental Accident Benefits also are available if the initial treatment is not received within 48 hours of an accidental injury. Supplemental Accidental Benefits are not subject to any deductible, coinsurance or out-of-pocket amount; however, Supplemental Accident Benefits are subject to the limitations described in Section 11. If there are any balances left after Supplemental Accident Benefits are exhausted, these balances are eligible for reimbursement subject to the terms of the Carve-Out Program including the deductible, coinsurance and out-of-pocket provisions.

SECTION 4
HOSPTAL SERVICES

The Carve-Out Program will cover services at a Hospital (defined below) either as an inpatient or as an outpatient. Generally, when a Member receives care at a Hospital, the services include both a professional component and an institutional component. For example, if the Member has surgery, the Hospital may charge the Member for the operating room and equipment while the surgeon, anesthesiologist and radiologist may charge separately for their services. Coverage for professional services of Health Care Practitioners are described in Section 3; the coverage described in this Section applies to the institutional services that are provided and billed by the Hospital.

4.1 Hospital Defined. The benefits of this Section apply only to institutions that are operated in accordance with the laws regulating Hospitals within the jurisdiction in which they are located and are primarily engaged in providing, for compensation on an inpatient basis, diagnostic and therapeutic facilities for surgical and/or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed doctors of medicine, and which continuously provides twenty-four (24) hour a day nursing service by registered graduate nurses, and which is not, other than incidentally, a place for the aged, or a nursing or convalescent home or institution.

In addition, a Non-Participating Hospital must be a general, maternity, mental, children's, or eye, ear, nose and throat Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations or its successors (or, by the duly constituted authority in the District of Columbia or the state in which it is located).

4.2 Inpatient Hospital Services. The following inpatient Hospital services are covered:

A. Semiprivate room (2 or more patients);

B. Private room and board accommodations but only if:

1. no semiprivate rooms are available at the time of admission (until one becomes available) or

2. the Member must be isolated to prevent contagion; or

3. the law requires isolation due to a communicable disease or an infectious condition.

C. Operating, recovery, anesthesia, intensive care, coronary care and cystoscopic room;

D. 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 and postnatal care is available for Employee/Members, and Dependent Spouses. Following childbirth, coverage will be provided for a minimum Hospital stay of not less than 48 hours following an uncomplicated vaginal delivery, or 96 hours following an uncomplicated cesarean section.

If the delivery occurs in the Hospital the length of stay begins at the time of the delivery. If the delivery occurs outside of the Hospital the length of stay begins upon admission to the Hospital. The Member and provider may agree to an early discharge. Prior authorization is not required.

Routine newborn care is included while the mother is hospitalized for covered maternity care, provided the mother is a Member and eligible for maternity benefits. The mother may request that the newborn also remain in the Hospital for up to 4 days. Coverage is limited to routine newborn visits (not to exceed two visits) male circumcision, and up to

two (2) well baby post-partum visits. To qualify for coverage of other services, the newborn must be a Member in his or her own right;

E. Anesthesia materials;

F. Meals, including special diets;

G. General nursing service (private duty nursing is excluded);

H. Drugs and medicines provided by the Hospital while the Member is a patient in the Hospital, including intravenous solutions and injections, provided that such drugs and medications are listed in the latest edition of "The United States Pharmacopoeia Dispensing Information," "The American Hospital Formulary Service Drug Information" or "The American Medical Association Drug Evaluations" at the time they are administered to the Member;

I. Oxygen, including the use of equipment for its administration;

J. Blood handling; sera (including blood, blood plasma and blood expanders);

K. Inpatient diagnostic and treatment services provided and billed by the Hospital, including:

1. Diagnostic procedures, laboratory tests and x-ray services, which in turn include:
   a. electrocardiogram, electroencephalogram; tonography;
   b. laboratory services;
   c. diagnostic x-ray services, diagnostic ultrasound services;

2. Treatment and therapeutic services in connection with a covered procedure, including:

   a. chemotherapy (benefits for high dose chemotherapy are limited to that as described in Section 3.12);
   b. electroshock therapy;
   c. radiation therapy;
   d. radioisotope services.
   e. physical therapy and inhalation therapy

L. 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 under the Program.

4.3 Outpatient Hospital Care. The following outpatient services rendered in the outpatient department of a Hospital or in an ambulatory surgical facility, in connection with a covered medical or surgical procedure under Section 3 are covered:

A. Use of operating room and recovery room;

B. Use of special procedure rooms;

C. Hemodialysis;

D. Laboratory, x-ray and machine tests;

E. Chemotherapy and radiation therapy (benefits for high dose chemotherapy are limited to that described in Section 3.12);

F. 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. 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.

4.4 Emergency Services. Those health care services are covered 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 in:

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

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

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.

SECTION 5
HOME HEALTH CARE SERVICES

5.1 Qualified Home Health Agency. The services described in Section 5.2 are covered only when the patient is under the care of a Qualified Home Health Agency, as defined below.

A Qualified Home Health Agency is a licensed program which is a Participating Provider or which is 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 or any successor.

5.2 Covered Home Health Care. The home health services listed below are covered when care is received from a Qualified Home Health Agency, subject to CareFirst's certification of the need and continued appropriateness of such services in accordance with the Program's utilization management requirements. See Section 2.

A. Part-time or intermittent home nursing care by a licensed professional (LPN or RN) nurse.

B. Respiratory, speech, audiology, physical and occupational therapy that CareFirst determines will result in improvement of a Member's condition and achieve demonstrable treatment objectives, as identified in the Qualified Home Health Agency's treatment plan.

C. Part-time or intermittent home health aide services.

D. Drugs and medications directly administered to the patient during a covered home health visit, including home intravenous infusion therapy and incidental medical supplies directly expended in the course of a covered home health visit. Drugs and medications that may be self-administered and are not taken under the direction of a physician (other than as described above) are not covered unless under a separate Attachment. Medical supplies and purchase or rental of durable medical equipment are covered under Section 9.

E. Diagnostic tests and laboratory services.

F. Services of a medical social worker.

G. Nutrition guidance under the direction of a registered dietitian.

H. Ambulance services to or from a Hospital when a Member's condition is such that other methods of transportation would be hazardous to his or her health.

5.3 Conditions for Coverage. Home Health Services must be authorized or approved by CareFirst under utilization management requirements as meeting the following conditions for coverage:

A. The Member must be confined to "home" due to a medical condition. "Home" cannot be an institution, convalescent home or any facility which is primarily engaged in rendering medical or rehabilitative services to sick, disabled or injured persons.

B. The home health visits must be a substitute for Hospital care or for care in a Hospice Facility (i.e., if home health visits were not provided, the Member would have to be admitted to a Hospital or Hospice Facility).

C. The Member must require and continue to require Home Health care or rehabilitation services. "Home Health care" means non-custodial care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

D. The home health services must not constitute custodial care (see Section 5.5).

E. The plan of treatment covering the Home Health Care service is established and approved in writing by the attending physician.

F. Services of a home health aide, medical social worker or registered dietitian must be performed under the supervision of a licensed professional (L.P.N. or R.N.) nurse.

G. All services must be arranged and billed by the Qualified Home Health Agency. Home health care providers may not be retained directly by the Member.

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

5.5 Custodial Care Is Not Covered. Benefits (for home health services or any other services) will not be covered if CareFirst determines that such visits or services were provided primarily for custodial care. Custodial care is care that does not require the continuing attention of trained, professional medical personnel. Custodial Care is care that is primarily for the purpose of meeting personal, daily living needs and that can be learned and provided by an average individual who does not have professional medical skills and training. Examples of custodial care include:

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

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

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

These services are custodial even if the Member cannot provide this care for himself or herself because of age or illness and even if there is no one in the Member's household who can perform these services for the Member.

SECTION 6
SKILLED NURSING FACILITY SERVICES

6.1 Covered Skilled Nursing Facility Services. The services listed below are covered only if they are provided in a "Qualified Skilled Nursing Facility," as defined below, and are provided during a confinement approved by CareFirst. Coverage for Skilled Nursing Facility Services will not be provided unless CareFirst certifies the need for Skilled Nursing Facility confinement and the appropriate length of stay for such confinement in accordance with its Utilization Management Requirements. See Section 2.

A. Room and board in a semiprivate room.

B. The following inpatient physician and medical services, if CareFirst determines that the Health Care Practitioner rendered the services and that such services were medically required to diagnose or treat the Member's condition. In addition, these services must be rendered during a confinement approved by CareFirst:

1. Health Care Practitioner visits during a Skilled Nursing Facility stay; one per day (additional if warranted by the complexity of the Member's condition)

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

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

1. Use of special equipment in the facility;

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

6.2 Qualified Skilled Nursing Facility. A "Qualified Skilled Nursing Facility" is a licensed facility that is approved for participation as a Skilled Nursing Facility under Medicare, or certified as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or any successor. 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.

6.3 Conditions for Coverage. Skilled Nursing Facility care must be authorized or approved by CareFirst and must meet the following conditions before services provided in such facility will be covered:

A. The admission to the Skilled Nursing Facility must be a substitute for Hospital care (i.e., if the Member was not admitted to a 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 that:

1. Are required on a daily basis;
2. Are not considered Custodial Care (see Section 5.4); and
3. Can only be provided on an inpatient basis.

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

SECTION 7
HOSPICE CARE SERVICES

7.1 Covered Hospice Care Services. Coverage will be provided for the services listed below when provided by a Qualified Hospice Care Program, as defined below. Coverage for Hospice Care Services is subject to a requirement that CareFirst certify in advance the need for and continued appropriateness of such services in accordance with its utilization management requirements, set forth in Section 2.

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

B. Medical social services for the terminally ill patient and his or her "Immediate Family." Immediate Family means the patient's spouse, Domestic Partner, and children or, if the terminally ill patient is a child, the parents, brothers and sisters of the child;

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

D. Non-custodial home health visits as described in Section 5;

E. 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.

F. Laboratory tests and x-ray services.

G. Ambulance services, when medically required.

H. Family Counseling will be provided to the Immediate Family and the Family Caregiver before the death of the terminally ill Member when authorized or approved by CareFirst. "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 death of the Member. "Family Caregiver" means a relative by blood, marriage, Domestic Partner, or adoption who lives with or is the primary caregiver of the terminally ill Member.

I. Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Member for the 6-month period following the Member's death or 15 visits, whichever occurs first. "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.

J. Respite Care will be limited to an annual benefit of 14 days. "Respite Care" means temporary care provided to the terminally ill Member to relieve the Family Caregiver from the daily care of the Member.

7.2 Conditions for Coverage. To be covered, the Hospice Care Services must be provided by a Qualified Hospice Care Program (as defined below) and meet the following conditions:

A. The Member must have a life expectancy of six months or less;

B. The Member's attending physician must submit a written plan of treatment to CareFirst;

C. The Member must meet the criteria of the Qualified Hospice Care 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's utilization management requirements.

7.3 Qualified Hospice Care Program. A "Qualified Hospice Care Program" is 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.

7.4 Hospice Stay Period. A Hospice Stay Period begins on the first date hospice services are rendered and terminates 180 days later or on the death of the terminally ill Member, if sooner. In individual cases, a Member, or representative of the Member, can petition CareFirst to review the Member's case and authorize an extension of coverage. CareFirst reserves the right to extend the eligibility period for up to 30 additional days of outpatient services or 14 additional days of inpatient care on an individual case basis, if it determines that the patient's prognosis and continued need for services are consistent with a program of Hospice Care.

7.5 Hospice Benefits Not Provided. The following services are not covered the Hospice Care:

A. Services, visits, medical equipment or supplies that are not included in CareFirst's approved plan of treatment;

B. Financial and legal counseling;

C. Any service 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.

SECTION 8
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

8.1 Covered Mental Health and Substance Abuse Care Services. Coverage will be provided for the services listed below for diagnosis, care and treatment of Mental Health and Substance Abuse, as defined in Section 8.2. Coverage is subject to the limits described in the Schedule of Benefits including limits on the numbers of visits and days the Program will cover and, if applicable, limitations on the total benefits available for these services. In addition, coverage is subject to a requirement that CareFirst certify in advance the need for and continued appropriateness of such services in accordance with our utilization management requirements; see Section 2.

8.2 Mental Health Conditions and Substance Abuse.

A. **Mental Health**. Coverage for services required in connection with the diagnosis, care or treatment of Mental Health, as defined below, will be provided solely under and subject to the terms and conditions described in this Section. For the purposes of determining if services are covered, "Mental Health" means any illness, condition, syndrome, symptom, or group or complex of symptoms that relates to or manifests itself as an emotional disorder, mental or behavioral deficit, abnormality or dysfunction. These will be deemed to be mental health conditions, rather then medical conditions, notwithstanding whether the illness, condition, disorder, etc. is caused by physical, genetic, psychiatric, psychological, chemical, biological, social or environmental factors, and regardless of the type of provider or type of treatment, procedure or regimen utilized.

B. **Substance Abuse** means a disease that is characterized by a pattern of pathological use of alcohol and or a drug and repeated attempts to control its use, and which has caused significant harmful effects in at least one of the following aspects of the Member's daily life: medical, legal, financial or psycho-social.

8.3 Outpatient Mental Health and Substance Abuse Services. The following services will be covered, subject to the terms and conditions outlined below and in accordance with the limits described in the Schedule of Benefits:

A. Diagnosis and treatment for Mental Health at physician offices, at other outpatient medical offices and facilities and at Qualified Partial Hospitalization Programs;

B. Diagnosis and treatment for Substance Abuse as defined above, including detoxification and rehabilitative services as an outpatient in a covered alcohol or drug rehabilitation program or Qualified Partial Hospitalization Program;

C. Other covered medical and medical ancillary services will be covered for conditions related to Mental Health and Substance Abuse on the same basis as other covered medical conditions.

D. Coverage for psychological and neuropsychological testing is provided for outpatient services to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse including psychological and neuropsychological testing for psychological diagnostic purposes. Services include evaluation, diagnosis and treatment of acute and non-acute conditions. The benefits for neuropsychological testing are not counted toward any outpatient mental health and substance abuse visit benefit.

8.4 Medication Management Office Visits. Office visits for medication management in connection with Mental Health and Substance Abuse will be covered in the same manner as medication management visits for physical illnesses and will not be counted as outpatient mental health or substance abuse treatment visits. Prior authorization is not required for Methadone Maintenance Treatment..

8.5 Partial Hospitalization. Benefits are available for partial hospitalization in a Qualified Partial Hospitalization Program as defined below, subject to the limits described in the Schedule of Benefits.

A **Qualified Partial Hospitalization Program** means a licensed or certified facility or program that provides medically directed intensive or intermediate short-term treatment for Mental Health and Substance Abuse for a period of less than 24 hours but more than 4 hours in a day.

8.6 Halfway House Facility. Benefits are available for Halfway House Facility in an approved transitional facility as defined below, subject to the limits described in the Schedule of Benefits.

Halfway House Facility means a transitional residential facility approved by the Department of Health and Mental Hygiene for the State of Maryland that offers treatment services at least 4 hours per week for the treatment of mental illnesses, emotional disorders and drug and alcohol abuse.

8.7 Inpatient Services. Coverage will be available for inpatient treatment of Mental Health and Substance Abuse. When the Member is an inpatient in a Hospital or other Program-approved Health Care facility for treatment of Mental Health and/or Substance Abuse, services will be covered as follows:

A. Hospital benefits will be provided, as described in Section 4, on the same basis as provided for a physical illness (non-Mental Health or Substance Abuse) admission, up to the limits described in the Schedule of Benefits.

B. The following Inpatient Health Care Practitioner benefits apply only if they are provided on a day in which the Hospital stay is covered:

1. Health Care Practitioner visits during the Member's Hospital stay; one per day (additional if warranted by the complexity of the Member's condition);

2. Intensive care which 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. Benefits are available for more than one inpatient visit per day if warranted by the complexity of condition.

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

Coverage for inpatient Mental Health and Substance Abuse Services is subject to CareFirst's certification of the need and continued appropriateness of such services in accordance with its utilization management requirements.

C. Diagnosis and treatment for Substance Abuse will be covered, including inpatient detoxification and rehabilitative services in an acute care Hospital or Qualified Treatment Facility, as defined below,

A Qualified Treatment Facility means a non-residential facility or distinct part of a facility, which is licensed in the jurisdiction(s) in which it operates and accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) as a substance abuse and alcohol treatment facility and which operates a program for the treatment and rehabilitation of alcohol and drug abuse.

Members must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs.

8.8 Residential Crisis Services

A. Residential Crisis Services are intensive mental health and support services that are:

1. Provided to a Dependent child or an adult Member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the ability of the Member to function in the community; and

2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency departments; and

3. Provided by entities that are licensed by the State of Maryland Department of Health and Mental Hygiene or the applicable licensing laws of any State or the District of Columbia to provide Residential Crisis Services; or

4. Located in subacute beds in an inpatient psychiatric facility, for an adult Member.

B. These services must receive prior authorization. The Member or Health Care Provider should obtain approval prior to services being rendered. If there is a benefit reduction under the Contract for failure to obtain prior authorization for mental health care, then that reduction will be applied to benefits for these services.

SECTION 9
MEDICAL DEVICES AND SUPPLIES

9.1 Benefits Provided. Coverage will be provided for certain types of Medical Devices and Medical Supplies (as defined below). To qualify for benefits, the Member must be enrolled in the Program at the time that the supply, equipment, prosthetic or appliance is prescribed and received. The Medical Devices and Medical Supplies must be ordered by a provider. When Durable Medical Equipment is rented, the Member must continue to be eligible to receive benefits for the duration of time for which the equipment is authorized.

9.2 Definitions.

A. **Durable Medical Equipment** means equipment that:

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

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

C. **Medical Device**, as used in the Contract, means Durable Medical Equipment, Hearing Aid, Medical Supplies, Prosthetic and Orthotic Device.

D. **Medical Supplies** means items that:

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

E. **Orthotic Device** means orthoses and braces which:

1. Are primarily and customarily used to serve a therapeutic medical purpose;
2. Are prescribed by a Health Care Provider;

3. 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;

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

5. Include devices necessary for post-operative healing.

F. **Prosthetic Device** means a device which:

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

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

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

4. Is prescribed by a Health Care Provider; and

5. Is removable and attached externally to the body.

9.3 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.

Durable Medical Equipment or supplies associated or used in conjunction with Medically Necessary medical foods and nutritional substances.

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

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

C. **Medical Foods and Nutritional Substances**. Medically Necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a Health Care Provider qualified to provide the diagnosis and treatment in the field of the disorder/disease, as determined by CareFirst.

D. **Medical Supplies**

E. **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.

F. **Hearing Aids.** Covered Services for a minor Dependent child:

1. One Hearing Aid, prescribed, fitted and dispensed by a licensed audiologist for each hearing-impaired ear;

2. Non-routine services related to the dispensing of a covered Hearing Aid, such as assessment, fitting, orientation, conformity and evaluation.

9.4 Exclusions and Limitations.

A. Coverage will not be provided for purchase, rental or repair of:

1. Medical equipment/supplies of an expendable nature, except as specifically listed as a covered medical supply above. Non-covered supplies include incontinence pads or ace bandages.

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

3. Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member, i.e., exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench.

4. Eyeglasses or contact lenses (except as stated above), dental prostheses, or appliances. Benefits may be provided under another Section within this Description of Covered Services, or separate Attachment.

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

B. Coverage will be limited to the lower of the cost to purchase or rent, taking into account the length of time the Member is required or is reasonably expected to require the equipment, the durability of the equipment, etc.

C. 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, the Program will pay an amount which 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.

D. Coverage for the repair, maintenance or replacement of Covered Durable Medical Equipment will be limited as follows:

1. Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.

2. 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 continue to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the appliance, prosthetic, orthotic or equipment.

3. Replacement coverage is limited to once every two 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.

9.5 Responsibility of CareFirst. The Program 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 or orthotic devices, corrective appliances or durable medical equipment, whether or not covered under this Agreement.

SECTION 10
EXCLUSIONS AND LIMITATIONS

10.1 Medically Necessary (or Medical Necessity). Coverage will not be provided for any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.

10.2 Free Care. Coverage will not be provided for the cost of services that:

A. are furnished without charge;

B. would normally be furnished to the Member without charge; or

C. would have been furnished to the Member without charge if the Member were not covered either under the Program or under any other health benefits arrangement.

10.3 Routine Care of Feet. Coverage will not be provided for routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

10.4 Routine Dental Care. Coverage will not be provided for routine dental care such as services, supplies, or charges directly related to the care, filling, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. Benefits may be provided under a separate Attachment.

10.5 Oral Surgery. Except as otherwise provided in Section 3.10, Dental Services and Oral Surgery Services, 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 are excluded.

10.6 Cosmetic Services. Coverage will not be provided for Cosmetic Services (except for Mastectomy—Related Services and services for cleft lip or cleft palate or both).

10.7 Prescription Drugs. Except as otherwise provided in 3.22, Prescription Drugs, benefits will not be provided for prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment. 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, except as may be provided in a separate Attachment to this Contract, even though they may be dispensed or administered in a physician or provider office or facility.

10.8 Organ and Tissue Transplants. **Coverage is not provided for**:

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary, non-experimental skin grafts that are covered under the Contract.

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. Any service, supply or device related to a transplant that is not listed as a benefit in the Contract.

10.9 Neuromuscular Rehabilitation. Neuromuscular rehabilitation will be covered if limited to physical therapy services.

10.10 Other Exclusions. Coverage will not be provided for the following

A. Services or supplies received before the effective date of the Member's coverage under this Agreement.

B. Treatment of sexual dysfunctions or inadequacies limited to surgical implants for impotence (medical therapy and psychiatric treatment are not covered).

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

D. Treatment for weight reduction and obesity except for the surgical treatment of Morbid Obesity.

E. Speech therapy, occupational therapy or physical therapy, unless CareFirst determines that your condition is subject to improvement. Speech therapy for cleft lip and cleft palette is, however, covered. Coverage does not include nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

F. Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, physical conditioning, use of passive or patient-activated exercise equipment.

G. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.

H. Services to the extent they are covered by any governmental unit, except that services provided in Veteran's Administration or armed forces facilities, such as for non-service connected disabilities, for which the Member is liable will be covered.

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

J. 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.

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

L. Except for covered ambulance services, travel expenses, whether or not recommended by an Eligible Provider.

M. Services or supplies for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.

N. 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.

O. Partial removal of a nail without the removal of the matrix.

P. Infertility Services. Coverage will not be provided for:

1. Any costs associated with freezing, storage, and thawing of the female Member's

eggs and/or male Member's or donor sperm for future attempts.

2. IVF procedures and any related testing or service that includes the use of donor eggs.

3. Any charges associated with donor eggs.

4. Costs associated with the freezing and storage of fertilized eggs (embryos).

5. No infertility services (Artificial Insemination/Intrauterine Insemination or In-Vitro Fertilization) in which a surrogate is involved will be covered.

6. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures are not covered. When the Member has had a reversal of an elective male or female surgical sterilization procedure then:

   a. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of infertility of at least 2 years' duration following the reversal of an elective sterilization procedure in order for IVF procedures to be covered.

   b. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of at least 1 year of unprotected vaginal intercourse following the reversal of an elective sterilization procedure in order for artificial insemination to be covered.

7. All self-administered fertility drugs. Coverage will be provided for self-administered in-vitro fertilization drugs if the Group does not provide a Prescription Drug Benefits Plan.

Q. Any claim, bill or other demand or request for payment for health care services determined to be furnished as a result of a referral prohibited by Section I-302 of the Maryland Health Occupations Article.

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

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

T. Any service, supply or procedure which is not specifically listed in this Description of Covered Services as a covered benefit.

U. Biofeedback services.

V. Premarital lab work required by law.

W. Insulin injections or insulin therapy, unless covered under the Prescription Drug part of the Program.

X. Inpatient private duty nursing services.

Y. Services that are Experimental/Investigational or for any treatment, procedure, facility, equipment, drug, drug usage, device or supply which in CareFirst's judgment is not in

accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered.

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

AA. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services.

BB. Any service related to recreation activities. This includes, but is not limited to, sports, games, equestrian activities and athletic training, even though such services may be deemed to have therapeutic value.

CC. Non-medical, Health Care Provider services, including, but not limited to:

1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff;Administrative fees charges by a Health Care Provider to a Member to retain the Health Care Provider's medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Contract are limited to Covered Services rendered to a Member by a Health Care Provider.

DD. Services related to human reproduction other than specifically described in this Contract including, but not limited to maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a Member.

EE. Treatment of temporomandibular joint disorders unless otherwise stated.

FF. Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.

GG. Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.

HH. Habilitative Services for a Member 19 years and older.

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

JJ. Coverage for immunizations is limited to all childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and the following immunizations: anthrax, cholera, diphtheria, german measles, influenza, measles, mumps, pertussis, poliomyelitis, rabies, smallpox, tetanus, typhoid, typhus and yellow fever

SECTION 12
SCHEDULE OF BENEFITS

CareFirst pays only for Covered Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, and 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 Evidence of Coverage, 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.

DEDUCTIBLES
The Individual Deductible is $200 per Benefit Period. The Family Deductible is $400 per Benefit Period. The following amounts apply to the Deductible: • 100% of the Allowed Benefit for covered services that are subject to the Deductible, as stated in the Benefits chart below. If the Member has Individual Coverage, he or she must meet the Individual Deductible When Members are covered under Two-Party Coverage, each Member must satisfy his or her own Deductible by meeting the Individual Deductible. Members covered under Family Coverage can satisfy their own Deductible by meeting the Individual Deductible. In addition, if 2 covered family members separately meet their own Individual Deductibles, this will also satisfy the Deductible for all other covered family members. The following amounts may <u>not</u> be used to satisfy the Deductible: • Amounts incurred for failure to comply with the Utilization Management Program requirements • The portion of any provider charge that is in excess of the Allowed Benefit • Coinsurance, Copayments or Deductible(s) if any, for services covered under any Rider or Attachment, unless specifically provided in the Rider or Attachment. The Benefit chart, below, identifies whether a Covered Service is subject to a Deductible.
Deductible Carryover Provision
If the Member has Deductible expenses in the last three (3) months of one (1) calendar year he may be able to apply these expenses toward meeting his Deductible for the following year. The Member can apply these expenses to his next year's Deductible if the expenses apply to services that are subject to the Deductible and the Member did not exceed his Deductible in the prior year.

OUT-OF-POCKET LIMITS

The Individual Out-of-Pocket Limit is $1,000 per Benefit Period.

These amounts apply to the Out-of-Pocket Limit:

- Coinsurance for Covered Services;

When a Member reaches Out-of-Pocket Limit, no further Coinsurance will be required in that calendar year for services subject to the Out-of-Pocket Limit.

If the Member has Individual Coverage, the Member must meet the Individual Out-of-Pocket Limit

When Members are covered under Two-Party Coverage, each Member must satisfy his or her own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit.

Members covered under Family Coverage can satisfy their own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit. In addition, if 2 covered family members separately meet their own Individual Out-of-Pocket Limits, this will also satisfy the Out-of-Pocket Limit for all other covered family members.

The following amounts may not be used to meet the Out-of-Pocket Limits:

- The Deductibles;
- Coinsurance or Copayments, if any, for services covered under an Attachment, unless specifically provided in the Attachment;
- 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.

UTILIZATION MANAGEMENT NON-COMPLIANCE

Failure or refusal to comply with Utilization Management Requirements will result in:

Benefits for health care facility services associated with your care or treatment will be reduced by 20% up to a maximum penalty of $500.

LIFETIME MAXIMUM

There is a $ 1,000,000 Lifetime Maximum per Member.

BENEFITS

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE ?	CAREFIRST COVERS
PHYSICIAN AND PROVIDER SERVICES			
Preventive Services			
Child wellness (including immunizations, related lab tests and X-rays)	Up to age 18	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE ?	CAREFIRST COVERS
Preventive Services (continued)			
Screening Mammography	Age 35-39; one baseline mammogram of each breast. Age 40-49; one preventive mammogram of each breast every two calendar years or more frequently if recommended by a physician. Age 50 and over; one preventive mammogram of each breast each calendar year.	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit.
Routine GYN Exam	Limited to 1 per Benefit Periods Limited to a maximum payment of $75 per examination.	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit.
Routine PAP Smear	Limited to 1 per calendar year.	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit.
Adult preventive physical examinations (including related lab tests and X-rays)	Age 18 and over Limited to one examination every 2 calendar years Limited to a maximum payment of $75 per examination.	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit.
Benefits in excess of the $75 limit on adult preventive physical examinations		YES	80% of the Allowed Benefit
Immunizations for Members 18 years of age and older	Limited to a Maximum CareFirst payment of $45 per Benefit Period	NO	$15 per immunization The Lifetime Maximum does not apply to this benefit.

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE ?	CAREFIRST COVERS
Benefits in excess of the $15 per immunization and $45 Benefit Period Maximum		YES	80% of the Allowed Benefit
Prostate Cancer Services		NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit.
Osteoporosis Prevention and Treatment Services		NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit.
Diagnostic and Treatment Services			
Office visits, Allergy tests, sera and injections and Chemotherapy (oral)	None	YES	80% of the Allowed Benefit
Diagnostic lab, x-ray and machine tests	Limited to an aggregate amount of $500 for all services related to an illness in a Benefit Period. There is a separate limit of $500 (aggregate amount) for all services related to an accident per Benefit Period.	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Benefits for all services in excess of the aggregate amount of $500 per illness per Benefit Period; for all services in excess of the aggregate amount of $500 per accident per Benefit Period		YES	80% of the Allowed Benefit
Radiation therapy, chemotherapy (injection or intravenous)		YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE?	CAREFIRST COVERS
Emergency Treatment for Accidental Injury			
Initial care received within 48 hours after onset	None	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Supplemental Accident Benefits	Limited to an aggregate amount of $300 per accident for treatment received within 90 days of the accident	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Care received more than 48 hours after onset; or for follow-up services; or after Supplemental Accident Benefits are exhausted	None	YES	80% of the Allowed Benefit
Physical, Speech, Occupational Therapy and Spinal Manipulation Services			
Outpatient Services (physician office, medical facility or hospital)	Benefits for chiropractic/spinal manipulation services are limited to Members who are twelve (12) years of age or older	YES	80% of the Allowed Benefit
Inpatient Hospital Services	Must be authorized in advance under Utilization Management Requirements	YES	80% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Benefits for the remaining 20% of Allowed Benefit		YES	80% of the Allowed Benefit
Maternity and Related Services	Benefits are available for all female Members	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Surgical Care	Benefits apply on an inpatient or outpatient basis	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE?	CAREFIRST COVERS
Outpatient Private Duty Nursing Services		YES	80% of the Allowed Benefit
Prescription Drugs		YES	80% of the Allowed Benefit
Inpatient physician and Health Care Practitioner Services and Consultations			
Visits by the attending physician, per confinement A new confinement begins only if the Member does not receive inpatient Hospital Services for 60 consecutive days			
Visits 1 through 180, including up to 14 days of intensive care per confinement. A new confinement begins only if the Member does not receive inpatient Hospital Services for 60 consecutive days	Must be authorized in advance under Utilization Management Requirements	NO	80% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit.
Benefits for the remaining 20% of Allowed Benefit		YES	80% of the Allowed Benefit
Visits in excess of 180 days and/or for intensive care in excess of 14 days per confinement		YES	80% of the Allowed Benefit
Consultations			
1 consultation per physician per admission	Must be authorized in advance under Utilization Management Requirements	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Additional consultations by the same physician within the same admission		YES	80% of the Allowed Benefit
Inpatient ancillary services, including radiology and pathology		NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE?	CAREFIRST COVERS
Anesthesia Service	Benefits apply on an inpatient or outpatient basis when provided in connection with a covered procedure	NO	80% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit.
Anesthesia Service Benefits for the remaining 20% of Allowed Benefit		YES	80% of the Allowed Benefit
Ambulance Service	None	YES	80% of the Allowed Benefit
HOSPITAL SERVICES			
Inpatient Hospital Services			
Up to 180 days per confinement (including confinement for Mental Illness) A new confinement begins only if the Member does not receive inpatient Hospital Services for 60 consecutive days	Must be authorized in advance under utilization management program	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Additional days in excess of 180 days per confinement		YES	80% of the Allowed Benefit
Outpatient Hospital Services			
Outpatient Surgery	None	YES	80% of the Allowed Benefit
Diagnostic Lab, X-ray, Machine Tests and Radiation Therapy	Limited to an aggregate amount of $500 for all services related to an illness per Benefit Period; there is a separate limit of $500 (aggregate amount) for all services related to an accident per Benefit Period	YES	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE ?	CAREFIRST COVERS
Diagnostic Lab, X-ray, Machine Tests and Benefits for services in excess of the aggregate amount $500 per illness per Benefit Period; for all services in excess of the aggregate amount of $500 per accident per Benefit Period		YES	80% of the Allowed Benefit
Pre-admission Testing	Must be done within 7 days prior to a Hospital admission	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Emergency Room Treatment for Accidental Injury			
Initial care received within 48 hours after onset	None	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Supplemental Accident Benefits	Limited to an aggregate amount of $300 per accident for treatment received within 90 days of the accident.	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Care received more than 48 hours after onset or for follow-up services; or after Supplemental Accident Benefits are exhausted.		YES	80% of the Allowed Benefit
Cardiac Rehabilitation		YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE ?	CAREFIRST COVERS
HOSPITAL SERVICES (continued)			
Hemodialysis treatment	None	YES	80% of the Allowed Benefit
Intravenous therapy	None	YES	80% of the Allowed Benefit
Other Hospital outpatient services (radiation therapy, chemotherapy, injection or intravenous)	None	YES	80% of the Allowed Benefit
HOME HEALTH CARE			
Up to 40 home health care visits (up to 4 hours per visit) per Benefit Period	Must be authorized in advance under utilization management program	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Home health care visits in excess of 40 per Benefit Period		YES	80% of the Allowed Benefit
Up to 1 physician visit per 7 day period during a covered Home Health Care Admission	None	NO	80% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Benefits for the remaining 20% of Allowed Benefit		YES	80% of the Allowed Benefit
Physician visits in excess of 1 per 7 day period during a covered Home Health Care Admission	None	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE ?	CAREFIRST COVERS
SKILLED NURSING FACILITY SERVICES			
Up to 360 days per Benefit Period	Must be authorized in advance under utilization management program	NO	Limited to a Maximum payment of $30 a day up to a Maximum of $10,800 per Benefit Period The Lifetime Maximum does not apply to this benefit
Benefits in excess of the $30 a day limit and $10,800 Benefit Period maximum		YES	80% of the Allowed Benefit
Days in excess of 360 per Benefit Period		YES	80% of the Allowed Benefit
Visits by the Attending Physician Limited to 180 days per confinement A new confinement begins only if the Member does not receive inpatient Skilled Nursing Facility Services for 60 consecutive days	Skilled Nursing Facility visits are counted toward the benefit limit applicable to inpatient hospital visits. Each visit in a Skilled Nursing Facility counts as one inpatient hospital visit	NO	80% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Benefits for the remaining 20% of Allowed Benefit		YES	80% of the Allowed Benefit
Additional day in excess of 180 days per confinement		YES	80% of the Allowed Benefit
HOSPICE CARE SERVICES	Must be authorized in advance under utilization management program	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE ?	CAREFIRST COVERS
MENTAL HEALTH AND SUBSTANCE ABUSE CARE			
Outpatient Services			
Outpatient services		YES	80% of the Allowed Benefit
Neuropsychological Testing		YES	80% of the Allowed Benefit
Methadone Maintenance Treatment		NO	100% of Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount
Inpatient Services			
Up to 180 days per confinement A new confinement begins only if the Member does not receive inpatient treatment for 60 consecutive days	Must be authorized in advance under utilization management program Inpatient services for substance abuse are included with Inpatient Hospital Services in determining the number of days available	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Days in excess of 180 per confinement		YES	80% of the Allowed Benefit
Inpatient physician and Health Care Practitioner Services and Consultations			
Visits by the attending physician, per confinement. A new confinement begins only if the Member does not receive inpatient Hospital Services for 60 consecutive days			
Visits 1 through 180 per confinement A new confinement begins only if the Member does not receive inpatient treatment for 60 consecutive days.	Inpatient visits for substance abuse are included with inpatient visits to a Member while confined in a Hospital or Skilled Nursing Facility in determining the number of visits available	NO	80% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit

SERVICE	SPECIAL LIMITATIONS	SUBJECT TO DEDUCTIBLE ?	CAREFIRST COVERS
Inpatient physician and Health Care Practitioner Services and Consultations (continued)			
Benefits for the remaining 20% of Allowed Benefit		YES	80% of the Allowed Benefit
Visits in excess of 180 days per confinement		YES	80% of the Allowed Benefit
Consultations			
1 consultation per physician per admission		NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Additional consultations by the same physician within the same admission		YES	80% of the Allowed Benefit
Partial Hospitalization	Must be authorized in advance under utilization management program Limited to 60 days per Benefit Period	NO	100% of the Allowed Benefit The Lifetime Maximum does not apply to this benefit
Special Care Facility		YES	80% of eligible charges up to $25 per day
MEDICAL DEVICES AND SUPPLIES	None	YES	80% of the Allowed Benefit
Hair Prosthesis	Limited to a CareFirst payment of $350 per Benefit Period.	NO	100% of the Allowed Benefit
Hearing Aids for Minor Children	Limited to a maximum CareFirst payment of $1,400 every 36 months for one Hearing Aid for each hearing impaired ear.	NO	100% of the Allowed Benefit

ATTACHMENT D
DESCRIPTION OF COVERED SERVICES
FOR MEMBERS ENROLLED IN THE MEDICARE SUPPLEMENTAL PROGRAM

MEDICARE SUPPLEMENTAL
HEALTH CARE PLAN

The medical benefits described in this ATTACHMENT D are for employees who (1) have completed at least 5 years of continuous coverage under the plan prior to retirement, and (2) were hired by the County on or after January 1, 1987 or (3) were hired by the County prior to January 1, 1987, and had elected these benefits.

This Attachment D describes the medical services eligible for coverage under this Modified Health Care Program. The amount that the Modified Health Care Program pays for these covered services is set forth in Section 5.

SECTION 1
DEFINITIONS

1.1 Benefit Terms Defined. In addition to the previously defined terms, this Attachment uses certain other defined terms. These are generally defined in the Section in which they first appear. The following general terms are also used. When capitalized, these words have the following meaning:

Extended Care Facility: a facility that has been approved by the federal Medicare program, or would qualify for approval under the federal Medicare program, for reimbursement at the time the services are rendered.

Hospital: a facility that has been approved by the federal Medicare program, or would qualify for approval under the federal Medicare program, for reimbursement at the time the services are rendered.

Medically Necessary: services or supplies that (1) are proper and needed for the diagnosis, or treatment of the Member's medical condition; (2) are provided for the diagnosis, direct care, and treatment of the Member's medical condition; (3) meet the standards of good medical practice in the medical community of your local area; and (4) are not mainly for the convenience of the Member or the Member's doctor.

Medicare: the "The Health Insurance for the Aged Act," Title XVIII of the Social Security Act of 1965, as then constituted or later amended. Medicare is a federal program that provides Hospital and medical insurance for the aged and disabled.

Medicare Benefit Period: the period beginning on the day the Member is furnished inpatient Hospital services or inpatient Extended Care Facility services, during a month in which the member is entitled to benefits under Medicare Part A, and ends when the Member has been out of the Hospital or Extended Care Facility for sixty (60) consecutive days.

Medicare Eligible Expenses: expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare

Prescription Drug: any drug or medicine that requires a written prescription by federal law; and is dispensed by a licensed pharmacist or Provider.

Provider: any provider of health care services approved as a provider under Medicare, including but not limited to Hospitals, Skilled Nursing Facilities, Physicians and suppliers.

Reasonable means the cost actually incurred, excluding any part of an incurred cost found to be unnecessary in the efficient delivery of needed health services.

Schedule of Benefits: the table in Section 5 of this Attachment that states the specific amounts or limitations that apply to the benefits provided under this Modified Health Care Program.

SECTION 2
COVERAGE

2.1 Coverage Supplements Medicare. Coverage under this Attachment supplements the benefits available under Medicare. The Member should be enrolled continuously under Medicare during his coverage under this Attachment. If the Member is not enrolled in Medicare, the Modified Health Care Program will pay benefits as if the Member is enrolled in Medicare. The Schedule of Benefits, Section 5, lists the benefits of this Modified Health Care Program.

2.2 Amount of Benefits. The payment of benefits described below will never be more than the amount that a Provider actually charged for a service or supply.

A. Medicare Part A
For coverage of deductible and coinsurance amounts under Medicare Part A, the Modified Health Care Program will base its benefit payments on the amount(s) approved by Medicare.

B. **Medicare Part B**
The "Medicare Approved Amount" is the amount established by Medicare and paid for an expense determined to be medically necessary and covered by Medicare. Except as provided below, the Modified Health Care Program will base its benefit payments for Part B on the Medicare Approved Amount. A Provider who does not accept Medicare assignment of the claim may charge the Member more than the Medicare Approved Amount, up to the "Limiting Charge". The "Limiting Charge" is the maximum amount that a Provider may charge a Medicare beneficiary for a covered Part B service if the Provider does not accept assignment of the Medicare claim.

C. **Additional Benefits Not Covered by Medicare**. When your coverage includes benefits for other services and supplies that Medicare does not cover, the Schedule of Benefits, Section 5, will describe the Modified Health Care Program's benefit payments for these items.

2.3 Payment of Benefits.

A. If a Medicare Eligible Expense is billed by a Provider accepting assignment of the Member's Medicare benefits, the Modified Health Care Program will pay the covered portion of the Medicare Eligible Expense not paid by Medicare to the Provider directly, on the Member's behalf.

B. If a Medicare Eligible Expense is billed by a Provider not accepting assignment of the Member's Medicare benefits, the Modified Health Care Program will pay the covered portion of the Medicare Eligible Expense not paid by Medicare to the Member, or the Member may authorize the Modified Health Care Program to pay the Provider directly.

SECTION 3
EXCLUSIONS

3.1 Exclusions from Coverage. Unless otherwise stated in this Attachment the Modified Health Care Program will not provide benefits for the following:

A. Any charge that is not a Medicare Eligible Expense.

B. Any charge or portion of a charge to the extent that the Member obtained benefits (or, by enrolling and maintaining eligibility, could have obtained benefits) under Medicare, under any program of the federal government, or any other law.

C. Services or supplies that are not Medically Necessary.

D. Services or supplies for which the Member would not have been charged if the Member had not been covered under this Attachment.

E. Services or supplies received for a medical condition before the Member's Effective Date of Coverage under this Contract, or after the termination of his coverage under this Contract even if the medical condition first occurred while this Contract was in effect.

Exception: If the Member is Totally Disabled (as defined in Section 3.5 of the Certificate of Coverage) at the time his coverage under this Contract terminates, the Modified Health Care Program will provide benefits as described in the Certificate of Coverage (see Extension of Benefits).

F. If the Member lives in Maryland or the District of Columbia, services or supplies to the extent that the Member obtained or could have obtained benefits under a provision of a motor vehicle insurance contract required by federal or state no-fault motor vehicle insurance.

G. Services or supplies to the extent that the Member obtained or could have obtained benefits under a workers' compensation law or similar law.

H. Any claim, bill or other demand or request for payment for health care services that we determine was furnished as a result of a referral prohibited by Section I-302 of the Maryland Health Occupations Article.

I. Prescription Drugs which do not require a written prescription by federal law; are not dispensed by a licensed pharmacist or Provider; or are prescribed for preventive care or preventive treatment.

SECTION 4
MISCELLANEOUS PROVISIONS

4.1 Filing Claims.

A. The Member's claim must first be submitted to Medicare, either by the Member or by his Provider on the Member's behalf.

B. After Medicare benefits have been determined, Medicare will advise the Modified Health Care Program of its payment. If Medicare fails to notify the Modified Health Care Program of its payment, the Member (or his Provider) must file a claim with the Modified Health Care Program by submitting a copy of the Explanation of Medicare Benefits (EOMB).

C. All claims for covered services and supplies must be submitted to the Medicare Modified Health Care Program within 15-months after the date the services were rendered or the supplies were received. The Modified Health Care Program will only consider claims beyond the 15-month claims filing period if the Member became legally incapacitated prior to the end of the filing period.

SECTION 5
SCHEDULE OF BENEFITS

Coverage is only provided for those Medicare Eligible Expenses or any portion of those Medicare Eligible Expenses designated as covered under the Schedule of Benefits, below:

Hospitalization	Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
	Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
Medical Expenses	The Coinsurance amount of Medicare Part B Eligible Expenses, regardless of hospital confinement and subject to the Medicare Part B deductible, each Benefit Period.
Prescription Drugs	The reasonable cost of the Prescription Drug. Benefits are subject to a $25 deductible each Benefit Period.

NOTE: Benefits designed to cover deductible or coinsurance amounts under Medicare will be changed automatically to coincide with any corresponding changes in the applicable Medicare deductible or coinsurance amounts. In this event, the Modified Health Care Program reserves the right to adjust the subscription charges under this Contract.