CareFirst

Point of Service (POS)

High and Standard Option In-Area Plans

Employee and Retiree Plan Booklet

Montgomery County Government

Point of Service Option

High and Standard Option

In-Area Plans

Employee and Retiree Plan Booklet

Montgomery County Government

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

EVIDENCE OF COVERAGE

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

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.

CareFirst has provided this Evidence of Coverage, including any amendments or riders applicable thereto, to the Group in electronic format. Any errors, changes and/or alterations to the electronic data, resulting from the data transfer or caused by any person shall not be binding on CareFirst. Such errors, changes and/or alterations do not create any right to additional coverage or benefits under the Group's health benefit plan as described in the health benefit plan documents provided to the Group in hard copy format.

Group Name: Montgomery County Government
Point of Service High and Standard Option In- Area Plans
Employee and Retiree Plan Booklet

Account Number(s): 49289

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DEFINITIONS

The Evidence of Coverage uses certain defined terms. When these terms are capitalized, they have the following meaning:

Allowed Benefit means:

1. **Contracted Health Care Providers**: For a Health Care Provider that has contracted with CareFirst, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the Health Care Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.

2. **Non-Contracted Health Care Providers**:

   a. Non-Contracted health care practitioner: For a health care practitioner that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or established fee schedule which, in some cases, will be a rate specified by applicable law, except for non-contracted radiologists, anesthesiologists, pathologists, and surgical assistants, the Allowed Benefit will be the provider's actual charge. The benefit is payable to the Subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the health care practitioner. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.

   b. Non-Contracted hospital or health care facility: For a hospital or health care facility that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Member payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Subscriber or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments to United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the hospital or health care facility. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.

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

Adverse Decision means a utilization review determination that a proposed or delivered health care service covered under the Claimant's contract is or was not Medically Necessary, appropriate, or efficient; and may result in non-coverage of the health care service.

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 is: **January 1st** through **December 31st**.

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

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

Claims Administrator means CareFirst.

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

Contracted Health Care Provider means a Health Care Provider that has contracted with CareFirst.

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).

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

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

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

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

Dependent means a Member other than the Subscriber (such as the eligible spouse), meeting the eligibility requirements established by the Group, who is covered under this Evidence of Coverage.

Dependent includes a child who has not attained Limiting Age stated in the Eligibility Schedule irrespective of the child's:

1. Financial dependency on an individual covered under the Contract;
2. Marital status;
3. Residency with an individual covered under the Contract;
4. Student status;
5. Employment, unless the child is eligible to enroll in an eligible employer-sponsored health plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent, in which case the adult child is prohibited from being covered; or
6. Satisfaction of any combination of the above factors.

Domestic Partner means a person of same sex and opposite sex who cohabitates/resides with the Subscriber in a Domestic Partnership. Domestic Partnership means a relationship between a Subscriber and Domestic Partner that satisfies the Group's Domestic Partner requirements.

Note: References in this Evidence of Coverage to a Dependent spouse/child shall be construed to include a Domestic Partner/child of a Domestic Partner.

Direct Access Service means an outpatient service for which a POSPCP referral is not required in order to receive in-network benefits. Services directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an oncologist, chemotherapy, and radiation therapy are Direct Access Services. Additionally, Covered Services in the Schedule of Benefits that state "Direct Access Service" do not require a POSPCP referral to receive in-network benefits. Most Direct Access Services must be rendered by a Contracted Health Care Provider to be paid as in-network; CareFirst service representatives can advise which Covered Services may be rendered by a Contracted Health Care Provider/Non-Contracted Health Care Provider and still be treated as a Direct Access Service.

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

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

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

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

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

4. 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.

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

Experimental/Investigational means a service or supply that is in the developmental stage and in the process of human or animal testing excluding Controlled 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:

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

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

3. The Technology must improve the net health outcome;

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

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

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

FDA means the U.S. Food and Drug Administration.

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

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

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.

Health Care Provider means a hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide Covered Services.

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

Infertility means the inability to conceive after one year of unprotected vaginal intercourse.

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

Lifetime Maximum means the maximum dollar amount payable toward a Member's claims for Covered Services while the Member is covered under this Group Contract. Essential Health Benefits Covered Services are not subject to the Lifetime Maximum. See the Schedule of Benefits to determine if there is a Lifetime Maximum for Covered Services that are **not** Essential Health Benefits.

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

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

Medically Necessary or Medical Necessity means health care services or supplies that a Health Care Provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services or supplies are:

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

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

3. Not primarily for the convenience of a patient or Health Care Provider; and

4. 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, is enrolled either as a Subscriber or Dependent, and for whom payment has been received by CareFirst.

Non-Contracted Health Care Provider means a Health Care Provider that does not contract with CareFirst.

Non-Point-of-Service Primary Care Provider (Non-POSPCP) means any Health Care Provider that is not a POSPCP.

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

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

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

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription. 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.

Paid Claims means the amount paid by CareFirst for Covered Services. Inter-Plan Arrangements Fees and Compensation are also included in Paid Claims. Other payments relating to fees and programs applicable to CareFirst's role as Claims Administrator may also be included in Paid Claims.

Physical Therapy 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.

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

Plan of Treatment means the plan written and given to CareFirst by the attending Health Care Provider on CareFirst forms which shows the Member's diagnoses and needed treatment.

Point-of-Service Primary Care Provider (POSPCP) means a designated Health Care Provider chosen by the Member at the time of enrollment who contracts with CareFirst or with CareFirst BlueChoice, Inc. (BlueChoice) to render Covered Services as described in the Description of Covered Services. The contracted POSPCP has the obligation of referring Members within the Contracted Provider network.

Prescription Drug means: (i) a drug, biological or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;" (ii) drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such

treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.

Private Duty Nursing means Skilled Nursing Care that is not rendered in a hospital/Skilled Nursing Facility.

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.

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

1. The cancellation or discontinuance of coverage has only a prospective effect; or

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

Retail Health Clinic means mini-medical office chains typically staffed by nurse practitioners with an on-call physician. Services provided are non-emergency and non-Urgent Services. Examples of common ailments for which a reasonable, prudent layperson who possesses an average knowledge of health and medicine would seek Retail Health Clinic care, include but are not limited to: ear, bladder, and sinus infections; pink eye; flu; and strep throat.

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

Skilled Nursing Care, depending on the place of service/benefit, means:

<table>
<tr><th>Home Health Care</th><th>Outpatient
Private Duty Nursing Rider</th><th>Inpatient hospital/facility
Skilled Nursing Facility</th></tr>
<tr><td colspan="2">Medically Necessary skilled care services performed in the home, by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).</td><td rowspan="5">Skilled Nursing Care rendered on an inpatient basis, means care for medically fragile Members with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the Member's safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week.</td></tr>
<tr><td colspan="2">Skilled Nursing Care visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if visits were not provided, a Member would have to be admitted to a hospital or Skilled Nursing Facility).</td></tr>
<tr><td>Skilled Nursing Care services must be based on a Plan of Treatment submitted by a Health Care Provider.</td><td rowspan="2">Skilled Nursing Care must be ordered by a physician, and based on a Plan of Treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.</td></tr>
<tr><td>Services of a home health aide, medical social worker or registered dietician may also be provided but must be performed under the supervision of a licensed professional (RN or LPN) nurse.</td></tr>
<tr><td colspan="3">Skilled Nursing Care is not Medically Necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the Activities of Daily Living (ADL), including, but not limited to, bathing, feeding, and toileting is not Skilled Nursing Care.</td></tr>
</table>

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

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

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

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

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

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Evidence of Coverage are Individual, Individual and Child, Individual and Adult, Family except for Benefits for Members Entitled to Medicare (Medicare Complementary) in which case Type of Coverage means Individual coverage. Additional categories of coverage do not apply to Benefits for Members Entitled to Medicare. Each Medicare-eligible person, including a Medicare-eligible Dependent, will be enrolled in an Individual Type of Coverage category under the Group Contract.

Waiting Period means the period of time that must pass before an employee or dependent is eligible to enroll under the terms of the Group Health Plan. A Waiting Period determined by the Group may not exceed the limits required by applicable federal law and regulation.

ELIGIBILITY AND ENROLLMENT

2.1 **Requirements for Coverage**

The Group has the sole and complete authority to make determinations regarding eligibility and enrollment for membership in the Plan.

An eligible participant of the Group, and his or her Dependent(s) meeting the eligibility requirements established by the Group, may be covered under the Evidence of Coverage (see Eligibility Schedule) when all of the following conditions are met:

A. The individual elects coverage;

B. The individual is entitled to Medicare, if Medicare Complementary coverage applicable;

C. The Group accepts the individual's election and notifies CareFirst; and

D. Payments are made on behalf of the Member by the Group.

2.2 **Enrollment Opportunities and Effective Dates**

Eligible individuals may elect coverage as Subscribers or Dependents, as applicable, only during the following times and under the following conditions. If an individual meets these conditions, his or her enrollment will be treated as timely enrollment. Enrollment at other times will be treated as special enrollment and will be subject to the conditions and limitations stated in Special Enrollment Periods. Disenrollment is not allowed during a contract year except as stated in section 2.2.A and as stated in the Termination of Coverage section of the Evidence of Coverage.

A. **Open Enrollment Period**

Open Enrollment changes will be effective on the Open Enrollment effective date stated in the Eligibility Schedule.

1. During the Open Enrollment period, all eligible persons may elect, change, or voluntarily disenroll from coverage, or transfer coverage between CareFirst and all other alternate health care plans available through the Group.

2. In addition, Subscribers already enrolled in CareFirst may change their Type of Coverage (e.g., from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage.

B. **Newly Eligible Subscriber**

A newly eligible individual and his/her Dependents may enroll and will be effective as stated in the Eligibility Schedule. If such individuals do not enroll within this period and do not qualify for special enrollment as described below, they must wait for the Group's next Open Enrollment period.

C. **Special Enrollment Periods**

Special enrollment is allowed for certain individuals who lose coverage. Special enrollment is also allowed with respect to certain dependent beneficiaries. Enrollment will be effective as stated in the Eligibility Schedule.

These special enrollment periods are not the same as Medicare special enrollment periods.

If only the Subscriber is eligible under this Evidence of Coverage and dependents are not eligible to enroll, special enrollment periods for a spouse/Dependent child are not applicable.

Special enrollment for certain individuals who lose coverage is not applicable to retirees, if retirees are eligible for coverage; otherwise, references to an employee shall be construed to include a retiree.

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 Evidence of Coverage.

   b. Individuals eligible for special enrollment.

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

         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 2.2C.1.c.1), 2), or 3) of this section, and if applicable, paragraph 2.2C.1.c.4) of this section.

      2) When dependent loses coverage.

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

            (1) The dependent and the employee are otherwise eligible to enroll;
            (2) When coverage was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and
            (3) The dependent satisfies the conditions of paragraph 2.2C.1.c.1), 2), or 3) of this section, and if applicable, paragraph 2.2C.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 2.2C.1.b.2), or the employee satisfies the criteria of paragraph 2.2C.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 2.2C.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 2.2C.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 b.2) of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.

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 2.2C.1.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. 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, and a new dependent. A current employee, the employee's spouse, and the employee's dependent are described in this paragraph if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

3. Special enrollment regarding Medicaid and Children's Health Insurance Program (CHIP) termination or eligibility:

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

a. Termination of Medicaid or CHIP coverage. 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.

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

MEDICAL CHILD SUPPORT ORDERS

3.1 Definitions

A. Medical Child Support Order (MCSO) 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.

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, one that complies with The Child Support Performance and Incentive Act of 1998, as amended.

3.2 Eligibility and Termination

A. Upon receipt of an 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 an applicable Waiting Period for coverage the child will not be enrolled until the end of the Waiting Period.

The Subscriber must be enrolled under this Group Contract in order for the child to be enrolled. If the Subscriber is not enrolled when CareFirst receives the MCSO/QMSO, CareFirst will enroll both the Subscriber and the child, without regard to enrollment period restrictions. The Effective Date will be that stated in the Eligibility Schedule for a newly eligible Subscriber and a newly eligible Dependent child.

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 an 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's 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 an MCSO/QMSO does not reside with the Subscriber, CareFirst will:

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

B. Allow the non-insuring custodial parent or a Health Care 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 Health Care Provider of the Covered Services; or

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

TERMINATION OF COVERAGE

4.1 **Disenrollment of Individual Members**

The Group has the sole and complete authority to make determinations regarding eligibility and termination of coverage in the Plan.

The Group Health Plan will not rescind coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Group Health Plan will provide at least thirty (30) days advance written notice to each participant who would be affected before coverage is rescinded regardless of whether the Rescission applies to an entire group or only to an individual within the group.

Coverage of individual Members will terminate on the date stated in the Eligibility Schedule for the following reasons:

A. CareFirst may terminate a Member's coverage for nonpayment of charges when due, by the Group.

B. The Group is required to terminate a Member's coverage if the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.

C. The Group is required to terminate the Subscriber's coverage and the coverage of the Dependents, if applicable, if the Subscriber no longer meets the Group's eligibility requirements for coverage.

D. The Group is required to terminate a Member's coverage if the Member no longer meets the Group's eligibility requirements for coverage.

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

F. Except in the case of a Dependent child enrolled pursuant to an MCSO or QMSO, coverage of any Dependents, if Dependent coverage is available, will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract.

4.2 **Death of a Subscriber**

If Dependent coverage is available, in the event of the Subscriber's death, coverage of any Dependents will continue under the Subscriber's enrollment as stated in the Eligibility Schedule under termination of coverage Death of a Subscriber.

4.3 **Effect of Termination**

Except as provided under the Extension of Benefits for Inpatient or Totally Disabled Individuals provision, no benefits will be provided for any services received on or after the date on which the Member's coverage under this Evidence of Coverage terminates. This includes services received for an injury or illness that occurred before the effective date of termination.

4.4 **Reinstatement**

Coverage will not reinstate automatically under any circumstances.

CONTINUATION OF COVERAGE

5.1 Continuation of Eligibility upon Loss of Group Coverage

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

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

If a Member leaves their job to perform military service, the Member has the right to elect to continue their Group coverage including any Dependents for up to twenty-four (24) months while in the military. Even if continuation of coverage was not elected during the Member's military service, the Member has the right to be reinstated in their Group coverage when reemployed, without any Waiting Periods or pre-existing condition exclusions except for service-connected illnesses or injuries. If a Member has any questions regarding USERRA, the Member should contact the Plan Administrator.

5.2 Extension of Benefits for Inpatient or Totally Disabled Individuals

This section applies to hospital, medical or surgical benefits. During an extension period required under this section, a premium may not be charged. Benefits will cease as of 11:59 p.m., Eastern Standard Time, on the Subscriber's termination date unless:

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

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

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

B. **Definitions**
For the purpose of this section 5.2, the following terms are defined. The definitions of other capitalized terms are found in the definitions sections throughout this Evidence of Coverage.

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

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.

C. 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 Evidence of Coverage 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. Twelve (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 twelve (12) month extension of benefits is not provided. An individual is entitled to only one (1), twelve (12) month extension, not an inpatient twelve (12) month extension and an additional Totally Disabled twelve (12) month extension.

D. 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.

COORDINATION OF BENEFITS; SUBROGATION

6.1 Coordination of Benefits

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 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; and

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

B. Definitions

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

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

CareFirst Plan means this Evidence of Coverage.

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

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

The term Plan does not include:

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

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

3. Coverage regulated by a motor vehicle reparation law;

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

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

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

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

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

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

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

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

C. **Order of Benefit Determination Rules**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The Plan of the parent with custody of the child;

(2) The Plan of the spouse of the parent with the custody of the child;

(3) The Plan of the parent not having custody of the child; and then

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

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

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

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

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

2) Second, the benefits under the continuation coverage.

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

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

D. **Effect on the Benefits of this CareFirst Plan**

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

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

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

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

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

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

2. Insurance companies; or

3. Other organizations.

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

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

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

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

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

6.3 **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 Evidence of Coverage, 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 Evidence of Coverage.

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.

HOW THE PLAN WORKS

This health care benefits plan offers a choice of Health Care Providers. Payment depends on the Health Care Provider chosen, as explained below in the "Choosing a Provider" subsection below. Other factors that may affect payment are found in Referrals, COB, Subrogation, the Inter-Plan Arrangements Disclosure, Inter-Plan Programs Ancillary Services, Exclusions, and Utilization Management Requirements.

A. **Appropriate Care and Medical Necessity**

CareFirst works to make sure that health care is rendered in the most appropriate setting and in the most appropriate way. While ensuring that the Member receives the best care, this also helps to control health care costs. In order to make sure that the setting and treatment are appropriate, some Covered Services require review before a Member receives care. These services are marked throughout this Evidence of Coverage.

CareFirst will pay a benefit for Covered Services rendered by a Health Care Provider only when Medically Necessary as determined by CareFirst. Benefits are subject to all of the terms, conditions, and maximums, if applicable, as stated in this Evidence of Coverage.

B. **Choosing a Provider**

1. Member/Health Care Provider Relationship

   a. The Member has the exclusive right to choose a Health Care Provider. Whether a Health Care Provider contracts with CareFirst or not relates only to method of payment and does not imply that any Health Care Provider is more or less qualified than another.

   b. CareFirst makes payment for Covered Services but does not provide these services. CareFirst is not liable for any act or omission of any Health Care Provider.

2. Contracted Health Care Providers

   a. If a Member chooses a Contracted Health Care Provider, the cost to the Member is lower than if the Member chooses a Contracted Health Care Provider. Throughout the Schedule of Benefits, payments are listed as either "in-network" or "out-of-network."

   b. Claims will be submitted directly to CareFirst by the Contracted Participating Health Care Provider.

   c. CareFirst will pay benefits directly to the Contracted Health Care Provider and such payment is accepted as payment in full, except for applicable Member amounts.

   d. The Member is responsible for any applicable Deductible and Coinsurance or Copayment, as stated in the Schedule of Benefits.

   e. Point-of-Service Primary Care Providers (POSPCP)

      1) Many Contracted Providers have a special agreement with CareFirst. Each Member has chosen a POSPCP as part of enrollment in this health care benefits plan. When a Member receives services from the POSPCP or as a result of referral by the POSPCP, payment will be made as "in-network." Direct Access Services listed in the Schedule of Benefits do not require a referral to be paid as "in-network."

2) Two POSPCP networks are available through CareFirst:

a) POSPCPs who contract with CareFirst of Maryland, Inc.

b) POSPCPs who contract with CareFirst BlueChoice, Inc.

A Member may choose a POSPCP from either network; a Health Care Provider will be a Contracted Provider only when the Health Care Provider is in the same network as the POSPCP.

3. Non-Contracted Health Care Providers

Except as otherwise authorized by CareFirst, if a Member chooses a Non-Contracted Health Care Provider, Covered Services may be eligible for reduced benefits. When Covered Services are provided by a Non-Contracted Health Care Provider, out-of-network benefits apply.

a. Claims may be submitted directly to CareFirst or its designee by the Non-Contracted Health Care Provider, or the Member may need to submit the claim. In either case, it is the responsibility of the Member to make sure that proofs of loss are filed on time.

b. All benefits for Covered Services will be payable to the Subscriber, or to the Non-Contracted Health Care Provider, at the discretion of CareFirst.

c. In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the State of Maryland Department of Health and Mental Hygiene or the non-insuring parent if proof is provided that such parent has paid the Non-Contracted Health Care Provider.

d. Non-Contracted Health Care Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Member up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Member. Therefore, when Covered Services are provided by Non-Contracted Health Care Providers, Members should expect to pay additional amounts to providers that exceed the Allowed Benefit. The Member is responsible for the difference between CareFirst's payment and the Non-Contracted Health Care Provider's charge.

5. Ambulance Services Providers

a. For purposes of calculating the Member payment for Ambulance Covered Services, refer to the quick reference guide below.

Quick Reference Guide	
If a Member receives Covered Services from:	**Member liability:**
Contracted Ambulance Services Provider	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Contracted Ambulance Services Provider	Balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits and for the difference between the Allowed Benefit and the Non-Contracted Ambulance Services Provider's actual charge.

b. If a Member receives services from a Contracted Provider, the cost to the Member is lower than if the Member receives services from a Non-Contracted Provider.

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

D. **Claim Forms**
CareFirst provides claim forms for filing proof of loss. If CareFirst does not provide the claim forms within 15 days after notice of claim is received, the Member is considered to have complied with the requirements of this Evidence of Coverage as to proof of loss if the Member submits, within the time fixed in this Evidence of Coverage for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

E. **Proofs of Loss**
In order to receive benefits for services rendered by a Health Care Provider who does **not** contract with CareFirst, a Member must submit written proof of loss to CareFirst or its designee within the deadlines described below.

1. Claims for medical benefits must be submitted within fifteen (15) months following the dates services were rendered.

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 Evidence of Coverage. These claims must be submitted to CareFirst before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst deems necessary to process the claim. CareFirst provides forms for this purpose.

F. **Time of Payment of Claims**
Benefits payable under this Evidence of Coverage will be paid not more than thirty (30) days after receipt of written proof of loss.

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

H. **Assignment of Benefits**

A Member may not assign his or her right to receive benefits or benefit payments under this Evidence of Coverage to another person or entity except for routine assignment of benefit payments to a Contracted Health Care Provider rendering Covered Services.

I. **Evidence of Coverage**

Unless CareFirst makes delivery directly to the Subscriber, CareFirst will provide the Group, for delivery to each Subscriber, a statement that summarizes the essential features of the coverage of the Subscriber and that indicates to whom benefits are payable. Only one statement will be issued for each family unit.

J. **Notices**

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

K**.** **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.

REFERRALS

Referral Requirements

A. Except for Direct Access Services, in-network benefits for Covered Services rendered by Contracted Health Care Providers other than the Member's POSPCP are only provided when prior written referral by the POSPCP is obtained for the specified Covered Service.

1. Referrals made by a POSPCP are good for 120 days except as stated in Referral to a Specialist. A referral will specify the number of visits and types of services approved. Covered Services received by referral will be paid "in-network." Covered Services Incurred after the expiration of the referral, or Covered Services beyond what is specified in the referral, will be paid "out-of-network."

2. Direct Access Services do not require a POSPCP referral to receive in-network benefits.

3. Obstetric & Gynecological Services.

   a. A female Member may receive routine gynecological care from an obstetrician/gynecologist who is a Contracted Health Care Provider without a visit to her POSPCP first, if:

      1) The care is Medically Necessary, including care that is routine;

      2) After each visit for gynecological care, the obstetrician/gynecologist communicates with the Member's POSPCP about any diagnosis or treatment rendered; and

      3) The obstetrician/gynecologist confers with the POSPCP before performing any diagnostic procedure that is not routine gynecological care rendered during an annual visit.

   b. If a female Member did not choose an obstetrician/gynecologist as her POSPCP, benefits are available for an annual visit to an obstetrician/gynecologist who is a Contracted Health Care Provider without a visit to her POSPCP first, whether or not her POSPCP is qualified to and regularly does provide routine gynecological care.

   c. A female Member may receive Medically Necessary, routine obstetric and gynecological care from a certified nurse midwife who is a Contracted Health Care Provider or any other Contracted Health Care Provider authorized under the health occupations article to provide obstetric and gynecological services without a visit to her POSPCP first.

      A certified nurse midwife or other non-physician Health Care Provider authorized under the health occupations article to provide obstetric and gynecological services shall consult with an obstetrician/gynecologist with whom the certified nurse midwife or other Health Care Provider has a collaborative agreement, in accordance with the collaborative agreement, regarding any care rendered hereunder.

   d. A Member who is pregnant may receive a standing referral to an obstetrician:

      1) After the Member receives this standing referral, the obstetrician is responsible for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with CareFirst's policies and procedures, through the postpartum period;

2) A treatment plan is not required when a standing referral is to an obstetrician.

B. Referrals Quick Reference

For non-Direct Access Covered Services				
If a Member sees a:	**With POSPCP referral:**		**Without POSPCP referral:**	
	Services will be covered at:	**Member liability:**	**Services will be covered at:**	**Member liability:**
Contracted Health Care Provider	Covered Services will be paid at the in-network level of benefits.	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.	Covered Services will be paid at the out-of-network level of benefits **if** out-of-network benefits are provided; otherwise, no benefits will be provided.	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Contracted Health Care Provider	Covered Services will be paid at charges.	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.	Covered Services will be paid at the out-of-network level of benefits **if** out-of-network benefits are provided; otherwise, no benefits will be provided.	Balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits and for the difference between the Allowed Benefit and the Non-contracted Health Provider's actual charge.

For Direct Access Covered Services				
If a Member sees a:	**With POSPCP referral:**		**Without POSPCP referral:**	
	Services will be covered at:	**Member liability:**	**Services will be covered at:**	**Member liability:**
Contracted Health Care Provider	Covered Services will be paid at the in-network level of benefits.	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.	Covered Services will be paid at the in-network level of benefits.	No balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.
Non-Contracted Health Care Provider	Covered Services will be paid at the out-of-network level of benefits **if** out-of-network benefits are provided; otherwise, no benefits will be provided.	Balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits and for the difference between the Allowed Benefit and the Non-contracted Health Provider's actual charge.	Covered Services will be paid at the out-of-network level of benefits **if** out-of-network benefits are provided; otherwise, no benefits will be provided.	Balance billing permitted: The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits and for the difference between the Allowed Benefit and the Non-contracted Health Provider's actual charge.

If a POSPCP refers a Member to a Non-Preferred Provider, CareFirst will pay the Non-Preferred Provider's charge with no balance billing to the Member, but the other provisions for Non-Preferred Providers stated in this Evidence of Coverage still apply.

UTILIZATION MANAGEMENT REQUIREMENTS

Failure to meet the requirements of the utilization management or to obtain prior authorization for services may result in a reduction or denial of the Member's benefits even if the services are Medically Necessary.

A. Plan of Treatment

Certain outpatient services indicated throughout this Evidence of Coverage require CareFirst's approval of a Plan of Treatment before benefits for Covered Services are provided; a penalty may apply if such approval is not obtained.

1. A health care practitioner must complete and submit a Plan of Treatment.

2. CareFirst must approve the Plan of Treatment before benefits for treatment can begin or continue.

3. Approval for coverage of any service is based on Medical Necessity as determined by CareFirst.

4. Within the Service Area, a Contracted Health Care Provider will complete and submit a Plan of Treatment. Outside the Service Area, the Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by a Health Care Provider, regardless of whether the provider is a Contracted Health Care Provider or a Non-Contracted Health Care Provider.

5. Services for which CareFirst must approve a Plan of Treatment:

   a. Controlled Clinical Trial Patient Cost coverage

      If the Plan of Treatment is not submitted, benefits will be denied.

      If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

   b. Home Health Care

      If the Plan of Treatment is not submitted, benefits will be denied.

      If the Plan of Treatment is submitted late (forty-eight (48) hours after commencing Home Health Care), the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

   c. Hospice Care

      If the Plan of Treatment is not submitted, benefits will be denied.

      If the Plan of Treatment is submitted after commencing hospice care, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

   d. Infertility Services

      If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted after commencing Infertility services, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

e. Habilitative Services

CareFirst must approve the Plan of Treatment after the 1st visit (hereafter, referred to as the "Initial Visit(s)").

If a Member requires additional treatment after the initial Plan of Treatment is completed, a subsequent Plan of Treatment is required **prior** to the first visit. That is, the Initial Visit(s) exemption from the Plan of Treatment requirement stated above, is only available once per lifetime, per Member, while covered by CareFirst.

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted late, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.

f. Private Duty Nursing

If the Plan of Treatment is not submitted, benefits will be denied.

If the Plan of Treatment is submitted after commencing private duty nursing, upon CareFirst's approval of the Plan of Treatment, benefits will be reduced 20%.

C. Hospital Pre-Certification and Review

A Contracted Health Care Provider will obtain Hospital Pre-Certification and Review. The Member is responsible for ensuring a Non-Contracted Health Care Provider obtains Hospital Pre-Certification and Review, both in and out of the Service Area.

1. Hospital Pre-Certification and Review Process

a. CareFirst may perform the review or may appoint a review agent. The telephone number for obtaining review is printed on the back of the membership card.

b. The reviewer will screen the available medical documentation for the purpose of determining the Medical Necessity of the admission, length of stay, appropriateness of setting and cost effectiveness and will evaluate the need for discharge planning.

c. Procedures which are normally performed on an outpatient basis will not be approved to be performed on an inpatient basis, unless unusual medical conditions are found through Hospital Pre-Certification and Review.

d. Pre-operative days will not be approved for procedures unless Medically Necessary.

e. The reviewer will assign the number of days certified based on the clinical condition of the Member and notify the Health Care Provider of the number of days approved.

f. CareFirst's payment will be based on the inpatient days approved by the reviewer.

g. CareFirst will provide outpatient benefits for Medically Necessary Covered Services when the reviewer does not approve services on an inpatient basis.

h. Hospital Pre-Certification and Review is not applicable to maternity admissions.

2. Non-Emergency (Elective) Admissions

a. The Member must provide any written information requested by the reviewer for Hospital Pre-Certification and Review of the admission at least twenty-four (24) hours prior to the admission.

b. The reviewer will make all initial determinations on whether to approve an elective admission within two working days of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider and Member of the determination.

c. For In-Network Covered Services:

1) CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.

2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the elective admission was Medically Necessary:

a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 20%;

b) The Member is responsible for this penalty.

d. For Out-of-Network Covered Services:

1) CareFirst will not provide benefits for an elective admission which is not Medically Necessary. The Member is responsible for the entire admission.

2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the elective admission was Medically Necessary:

a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 20%;

b) The Member is responsible for this penalty.

3. Emergency (Non-Elective) Admissions

a. The Member, the Health Care Provider or another person acting on behalf of the Member must notify the reviewer within twenty-four (24) hours following the Member's admission, or as soon thereafter as reasonably possible.

The reviewer may not render an Adverse Decision or deny coverage for Medically Necessary Covered Services solely because the hospital did not notify

the reviewer of the emergency admission within twenty-four (24) hours if the Member's medical condition prevented the hospital from determining:

1) The Member's insurance status; and

2) The reviewer's emergency admission notification requirements.

b. For an involuntary or voluntary inpatient admission of a Member determined by the Member's physician or psychologist, in conjunction with a member of the medical staff of the hospital who has privileges to admit patients to be in imminent danger to self or others, the reviewer may not render an Adverse Decision as to the Member's admission:

1) During the first twenty-four (24) hours the Member is in an inpatient facility; or

2) Until the reviewer's next business day, whichever is later.

The hospital shall immediately notify the reviewer that a Member has been admitted and shall state the reasons for the admission.

c. The reviewer will make all initial determinations on whether to approve a non-elective admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.

For non-elective admissions for which the reviewer receives notice but does not approve inpatient benefits, CareFirst will notify the hospital attending Health Care Provider that inpatient benefits will not be paid as of the date of notification.

1) A Member will have to pay:

a) All charges for any care received as of the date the Member receives notice by the hospital attending Health Care Provider, or CareFirst that further care is not Medically Necessary if the Member continues the inpatient stay.

b) Non-Contracted Health Care Providers if a non-elective admission results in payment denial.

2) A Member will not have to pay Contracted Providers:

a) If the Member is admitted and the admission is not Medically Necessary;

a) If a non-elective admission results in payment denial.

d. For In-Network non-elective admissions for which the reviewer does not receive notice and the reviewer determines the non-elective admission was Medically Necessary:

1) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 20%;

2) The Member is responsible for this penalty.

e. For Out-of-Network non-elective admissions for which the reviewer does not receive notice and the reviewer determines the non-elective admission was Medically Necessary:

1) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 20%;

2) The Member is responsible for this penalty.

Benefits will be provided subject to the terms of section B.3.a., above.

4. Continued Stay Review
The reviewer will make all determinations on whether to approve continuation of an admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider of the determination.

5. Discharge Planning
The reviewer will coordinate referrals for discharge planning activities if, in the discretion of the reviewer, a need for such coordination is indicated.

6. Program Monitoring

a. The Member's medical record will be reviewed by the reviewer.

b. The hospital may be requested to evaluate the medical records and respond to the reviewer if there is a delay in which care is not provided when ordered or otherwise requested by a Health Care Provider in a timely fashion or other delay.

c. During and after discharge, the reviewer may review the medical records to:

1) Verify that the services are covered under the Evidence of Coverage;

2) Ensure that the Health Care Provider is substantially following the Plan of Treatment.

7. Notice and Appeals

a. Written notice of any Adverse Decision is sent to the Health Care Providers and Member.

b. The Member or the Health Care Providers have the right to appeal Adverse Decisions in writing to CareFirst.

1) If the attending Health Care Provider believes the Adverse Decision warrants immediate reconsideration, the reviewer will afford the Health Care Provider the opportunity to seek a reconsideration of the Adverse Decision by telephone within 24 hours of the Health Care Provider's request.

2) For instructions on how to appeal an Adverse Decision, refer to the Claims Procedures of this Evidence of Coverage.

INTER-PLAN ARRANGEMENTS DISCLOSURE

Out-of-Area Services
CareFirst BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Group Contract are described generally below.

Typically, Members, when accessing care outside the geographic area CareFirst serves, obtain care from Health Care Providers that have a contractual agreement (i.e., are "PPO/Participating") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from Non-Participating Providers. CareFirst payment practices in both instances are described below.

A Member will be entitled to benefits for Covered Services accessed either inside or outside the geographic area CareFirst serves.

Member liability for Out-of-Area Covered Emergency Services is limited to the Member Payment for Emergency Services and Urgent Care as set forth in the Group Contract.

Due to variations in Host Blue network protocols, a Member may also be entitled to benefits for some healthcare services obtained outside the geographic area CareFirst serves, even though the Member might not otherwise have been entitled to benefits if he or she had received those healthcare services inside the geographic area CareFirst serves. But in no event will a Member be entitled to benefits for healthcare services, wherever he or she received them, that are specifically excluded from, or in excess of the limits of, coverage provided by this Group Contract.

A. Definitions

For purposes of Inter-Plan Programs, the underlined terms, when capitalized, are defined as follows:

Allowed Benefit, unless otherwise stated, or required by federal law, means the amount the Host Blue allows for a Covered Service regardless of whether the amount the Host Blue allows is greater or lesser than CareFirst's Allowed Benefit and is deemed a final amount.

BlueCard PPO Network Provider (PPO Provider) means a Health Care Provider who contracts with a Host Blue as part of its Preferred Provider Organization (PPO) network.

BlueCard Traditional Network Provider (Participating Provider) means a Health Care Provider who contracts with a Host Blue to be paid directly for rendering Covered Services to Members.

Non-Participating Provider means any Health Care Provider that does not contract with a Host Blue.

Preferred Provider Organization (PPO) means a healthcare benefit arrangement designed to supply services at a discounted cost by providing incentives for Members to use designated Health Care Providers (who contract with the PPO at a discount), but which also provides coverage for services rendered by Health Care Providers who are not part of the PPO network.

B. BlueCard® Program

Under the BlueCard® Program, when Members access Covered Services from a PPO Provider or Participating Provider within the geographic area served by a Host Blue, CareFirst will remain responsible to Group for fulfilling CareFirst contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for

providing such services as contracting and handling substantially all interactions with its PPO/Participating Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Whenever a Member accesses Covered Services outside the geographic area CareFirst serves and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for the Covered Services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Health Care Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Health Care Provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Health Care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price CareFirst uses for a claim because they will not be applied retroactively to claims already paid.

A small number of states require Host Blues either (i) to use a basis for determining Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst would then calculate Member liability and Group liability in accordance with applicable law.

Under certain circumstances, if CareFirst pays the Health Care Provider amounts that are the responsibility of the Member under this Group Contract CareFirst may collect such amounts from the Member.

C. Negotiated National Account Arrangements

Claims for Covered Services may be processed through a negotiated national account arrangement with a Host Blue.

The amount the Member pays for Covered Services, if not a flat dollar copayment, will be calculated based on the "price" made available to CareFirst. The "price" may be the:

1. Negotiated price/lower of either billed covered charges or negotiated price; or

2. Lower of either billed covered charges or negotiated price (refer to the description of negotiated price under paragraph B., BlueCard Program).

Under certain circumstances, if CareFirst pays the Health Care Provider amounts that are the responsibility of the Member under this Group Contract CareFirst may collect such amounts from the Member.

D. Non-Participating Providers Outside the CareFirst Service Area

Member Liability Calculation

1. In General

   When Covered Services are provided outside of the CareFirst service area by Non-Participating Providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

2. Exceptions

   In some exception cases, CareFirst may pay claims from Non-Participating Providers outside of CareFirst's service area based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a PPO/Participating Provider, as determined by CareFirst in CareFirst's sole and absolute discretion or by applicable state/federal law. In other exception cases, CareFirst may pay such claims based on the payment it would make if CareFirst were paying a Non-Contracted Provider inside of its service area, as described elsewhere in this Group Contract, where the Host Blue's corresponding payment would be more than CareFirst's in-service area Non-Contracted Provider payment, or in CareFirst's sole and absolute discretion, CareFirst may negotiate a payment with such a provider on an exception basis.

   Finally, CareFirst may pay up to billed charges for Group designated Covered Services.

   Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

Inter-Plan Programs Eligibility Claim Types
Unless otherwise stated, all claim types are eligible to be processed through the Inter-Plan Programs except for those Dental Care Benefits, Prescription Drug Benefits, or Vision Care Benefits that may be delivered by a third-party contracted by CareFirst to provide the specific service or services.

INTER-PLAN PROGRAMS ANCILLARY SERVICES

A. **Definitions**

Ancillary Services means, with respect to Inter-Plan Programs, the following Covered Services:

1. Independent clinical laboratory tests (performed at non-hospital based labs);
2. Medical Devices and Supplies; and
3. Specialty Prescription Drugs (including non-routine, biological therapeutics such as injectables, infusion therapies, high-cost therapies, and therapies that require complex care).

Remote Provider means, with respect to Ancillary Services an Ancillary Services provider located outside the geographic area a Blue Cross and/or Blue Shield plan serves, with which a Blue Cross and/or Blue Shield plan may contract under its Blue Cross and Blue Shield Association license agreement for Ancillary Services rendered in its service area and which are considered local providers.

B. **Member** Payment

Member payment for Ancillary Services is determined by the relationship between the provider and the Local Plan (which may be CareFirst).

If an Ancillary Services Remote Provider contract is in place with the Local Plan, the Remote Provider is a Contracted Health Care Provider/BlueCard PPO Network Provider/BlueCard Traditional Network Provider.

If an Ancillary Services Remote Provider contract is not in place with the Local Plan, the Remote Provider is a Non-Contracted Health Care Provider/Non-Participating Provider.

The Member is responsible for the Member payment as stated in the How the Plan Works section or Inter-Plan Arrangements Disclosure section of this Evidence of Coverage.

C. **Determining the Local Plan**

For Ancillary Services, the Local Plan is determined as follows:

Out-of-Network Covered Ancillary Service	**The Local Plan is the Blue Cross/Blue Shield plan in whose service area/state where the:**	
Independent clinical laboratory tests	Specimen was drawn, if the referring provider is located in the same service area.	Referring provider is located, if the provider is not located in the same service area where the specimen was drawn.
Medical Devices and Supplies	Medical Devices and/or Supplies were: • Shipped to; or • Purchased at a retail store.	
Specialty Prescription Drugs	Ordering/prescribing physician is located.	

BENEFITS FOR MEMBERS ENTITLED TO MEDICARE
(Medicare Complementary)

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

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. The Medicare Part A and Part B deductible and coinsurance is not the same as the Deductible or Coinsurance, defined in Definitions, which may be applied by CareFirst to Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures; however, the Utilization Management Requirements of this Evidence of Coverage do not apply to persons for whom Medicare is the primary carrier.

Members shall agree to complete and submit to Medicare, CareFirst and/or Health Care Providers contracted with CareFirst, all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

This coverage is not Medicare supplemental coverage. This coverage provides benefits for some charges and services not covered by Medicare. It is not designed to fill the "gaps" of Medicare.

Covered Services under Medicare Complementary are the same as under the Description of Covered Services. Only the manner of payment is different:

A. **Coverage Secondary to Medicare**
Except where prohibited by law, CareFirst benefits 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:

   a. For any Health Care Provider who accepts Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge.

   b. For any Health Care Provider who does not accept Medicare assignment, the combined Medicare payment and CareFirst payment will not exceed the limitation set by Medicare.

2. **For a Member who Elects Medicare Part B**: CareFirst will coordinate as described above and pay benefits based on Medicare's payment. For example, after meeting the Part B deductible, Medicare pays 80% of the Medicare approved amount for most doctor services; the basis for CareFirst's payment is the remaining 20% of the Medicare approved amount (the combined Medicare payment and CareFirst payment will not exceed the Medicare approved charge/limitation set by Medicare).

a. Numerical Example for a Member who Elects Medicare Part B:

Numerical example, assuming:	
Part B deductible has been met; **CareFirst Deductible, if applicable, has been met;** **CareFirst Coinsurance of either 100% or 80%; and** **Medicare approved charge does not exceed limitation set by Medicare, if applicable**	
Medicare approved amount	$ 1,000.00
Multiplied by 80% equals Medicare payment	$ 800.00
Basis for CareFirst's payment (remaining 20% of the Medicare approved amount)	$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	$ 160.00

3. **For a Member who Does not Elect Part B**: CareFirst will reduce its payment to "carve-out" or reject the 80% coinsurance Medicare would have paid if the Member had elected Part B.

a. If the amount Medicare would have paid is available, CareFirst will coordinate as described above, "carving-out" or rejecting the amount Medicare would have paid. CareFirst will base its reduced Coinsurance payment on the amount Medicare would have paid if the Member had elected Part B.

b. If the amount Medicare would have paid is not available, CareFirst will base its Coinsurance payment on 20% of the Allowed Benefit. The 80% reduction to the Allowed Benefit represents the amount that Medicare theoretically would have paid if the Member had elected Part B.

c. Numerical Examples for a Member who Does not Elect Part B:

1) In the first numeric example below, CareFirst's Allowed Benefit is assumed to be the same as the Medicare approved amount in the above example for a Member who elects Medicare Part B. In this example, CareFirst's payment does not differ; however, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	$ 1,000.00
Medicare payment	$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	$ 200.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	$ 200.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	$ 160.00

2) In the second numeric example below, CareFirst's Allowed Benefit is assumed to differ from the Medicare approved amount in the above example for a Member who elects Medicare Part B. Again, the Member is liable for the difference between CareFirst's payment and the Allowed Benefit for a Participating Provider, and for the difference between CareFirst's payment and the Health Care Provider's charge for a Non-Participating Provider.

Numerical example, assuming:	
the amount Medicare would have paid is not available; CareFirst Deductible, if applicable, has been met; CareFirst Coinsurance of either 100% or 80%	
CareFirst Allowed Benefit	$ 500.00
Medicare payment	$ 0.00
Basis for CareFirst's payment is 20% of Allowed Benefit	$ 100.00
Multiplied by 100% CareFirst Coinsurance equals CareFirst payment of	$ 100.00
OR multiplied by 80% CareFirst Coinsurance equals CareFirst payment of	$ 80.00

DESCRIPTION OF COVERED SERVICES

The services described herein are eligible for coverage under this Evidence of Coverage. CareFirst will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services Incurred by a Member, including any extension of benefits for which the Member is eligible. It is important to refer to the Schedule of Benefits to determine the percentage of the Allowed Benefit that CareFirst will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists other features that affect Member coverage, including, if applicable, the Deductible, Out-of-Pocket Maximum, and specific benefit limitations.

PREVENTIVE AND WELLNESS SERVICES

These are the minimum benefits offered. CareFirst may provide additional benefits in accordance with the CareFirst Preventive Guidelines.

A. Child Wellness
Child wellness benefits are available for infants, children and adolescents (newborn up to age 18), for:

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

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 is to be collected before 2 weeks of age;

3. Universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting;

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

5. Examinations including developmental assessments and parental anticipatory guidance; and

6. Laboratory tests necessary to provide these services.

B. Human Papillomavirus Screening

1. Definitions

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

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.

C. Colorectal Cancer Screening
Colorectal cancer screening provided in accordance with the latest guidelines issued by the American Cancer Society.

D. Mammography/Breast Cancer Screening
Mammography screening (by low-dose mammography) for the presence of occult breast cancer provided by a Health Care Provider that is approved by the American College of Radiology, or certified/licensed by the State of Maryland will be covered as follows:

1. One baseline screening for a Member thirty-five (35) to thirty-nine (39) years old;

2. One screening every twenty-four months or more frequently if recommended by a Health Care Provider for a Member forty (40) to forty-nine (49) years old;

3. One screening every twelve months for a Member fifty (50) years and over.

E. Osteoporosis Prevention

1. Definitions

Bone Mass Measurement means a radiologic or other scientifically proven technology for the purpose of identifying bone mass or detecting bone loss

Qualified Individual means a Member:

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

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

c. Receiving long term glucocorticoid (steroid) therapy;

d. With primary hyperparathyroidism; or

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

2. Covered Services

Bone Mass Measurement for the prevention and diagnosis of osteoporosis when requested by a Health Care Provider for a Qualified Individual.

F. Prostate Cancer Screening
Benefits are available for the detection of prostate cancer. Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal exams:

1. For men who are between forty (40) and seventy-five (75) years of age;

2. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;

3. When used for staging in determining the need for a bone scan for patients with prostate cancer; or

4. When used for male Members who are at high risk for prostate cancer.

G. Routine Gynecological (GYN) Exam

H. Routine Physical Exam (for a Member 18 years of age or older)

CONTROLLED CLINICAL TRIAL PATIENT COST COVERAGE

Controlled Clinical Trial Patient Cost benefits are available as follows:

A. Definitions

Controlled Clinical Trial means a treatment that is:

1. Approved by an institutional review board;

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

3. Is approved by:

   a. The National Institutes of Health (NIH) or a Cooperative Group.

   b. The Centers for Disease Control and Prevention.

   c. The Agency for Health Care Research and Quality.

   d. The Centers for Medicare & Medicaid Services.

   e. Cooperative group or center of any of the entities described in clauses 3.a) through 3.d) above or the Department of Defense or the Department of Veterans Affairs.

   f. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.

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

      1) To be comparable to the system of peer review of studies and investigations used by the NIH, and

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

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

   i. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the Aids Clinical Trials Group; and 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 United States Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

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

B. Covered Services

1. Benefits will be provided to a Member in a Controlled Clinical Trial if the Member's participation in the Controlled Clinical Trial is the result of:

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

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

2. Coverage will be provided only if:

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

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

   c. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

   d. There is no clearly superior, non-Experimental/Investigational treatment alternative; and,

   e. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Experimental/Investigational alternative.

   f. Prior authorization has been obtained from CareFirst.

3. Coverage is provided for the Patient Cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT TRAINING

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

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

EMERGENCY SERVICES AND URGENT CARE

A. Covered Services

1. Emergency Services and Urgent Care including, but not limited to:

   a. Accidental injury and trauma to the jaw, Sound Natural Teeth, mouth or face;

   b. Accidental injury and trauma supplemental services and supplies benefits, within 90 days, limited to:

      1) Medically Necessary ground ambulance services, as determined by CareFirst;

      2) Casts, splints, trusses, braces or crutches;

      3) Consultations by a Health Care Provider;

      4) Diagnostic services;

      5) Medical care and surgery;

      6) Physical Therapy;

      7) Prescription Drugs.

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

GENERAL ANESTHESIA FOR DENTAL CARE

A. Covered Services

1. Benefits for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a Member under the following circumstances:

   a. If the Member is:

      1) Seven years of age or younger, or developmentally disabled;

      2) An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member; and

      3) An individual for whom a superior result can be expected from dental care provided under general anesthesia.

   b. Or, if the Member is:

      1) Seventeen years of age or younger;

      2) An extremely uncooperative, fearful, or uncommunicative individual;

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

      4) An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.

   c. Or, if the Member has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.

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

      1) A fully accredited specialist in pediatric dentistry;

      2) A fully accredited specialist in oral and maxillofacial surgery; and

      3) A dentist who has been granted hospital privileges.

   e. This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.

   f. This provision does not provide benefits for the dental care for which the general anesthesia is provided.

HOME HEALTH CARE

A. Definitions

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

1. The Member's physician establishes and approves in writing the Plan of Treatment recommending the Home Health Care service; and

2. Institutionalization of the Member would have been required, and deemed Medically Necessary by CareFirst, if Home Health Care was not provided.

Home Health Care Visits:

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

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

B. Covered Services

1. Home Health Care, as defined above.

C. Limitations

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

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

3. The Member must require and continue to require Skilled Nursing Care or Rehabilitative Services in order to qualify for home health aide services or other types of Home Health Care. "Skilled Nursing Care," for purposes of Home Health Care, means care that requires licensure as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for performance.

4. Services of a home health aide, medical social worker or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).

HOSPICE CARE

A. Definitions

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

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

Respite Care means short-term care for a Member that provides relief to the Caregiver.

B. Covered Services

Hospice care benefits are available for a terminally ill Member (medical prognosis by a physician that the Member's life expectancy is six months or less) when the Member is under the care of a PCP or other Health Care Provider.

1. Inpatient hospice facility services;
2. Part-time nursing care by or supervised by a registered graduate nurse;
3. Counseling, including dietary counseling, for the Member;
4. Medical Supplies, Durable Medical Equipment and Prescription Drugs required to maintain the comfort and manage the pain of the Member;
5. Medical care by the attending physician;
6. Respite Care;
7. Other Medically Necessary health care services at CareFirst's discretion.

INFERTILITY SERVICES

Benefits are available when the Member is married or in a Domestic Partnership for the diagnosis and treatment of Infertility including Infertility counseling and Medically Necessary, non-Experimental/Investigational artificial insemination/intrauterine insemination and in vitro fertilization, as follows:

A. 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;

c. The use of donor sperm does not preclude the artificial insemination benefit from being available to the member. However, any charges associated with the collection of sperm will not be covered unless the male donor is also a Member.

B. In vitro fertilization:

1. Benefits are available when:

a. Outpatient benefits (including zygote and gamete intra-fallopian transfer) approved by the federal Food and Drug Administration that are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for IVF clinics, or the American Society for Reproductive Medicine minimal standards for IVF programs.

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

c. The use of donor sperm does not preclude the artificial insemination benefit from being available to the member. However, any charges associated with the collection of sperm will not be covered unless the male donor is also a Member.

INPATIENT/OUTPATIENT HEALTH CARE PROVIDER SERVICES
(ambulatory services; hospitalization; laboratory services)

A. Covered Services

1. Inpatient/outpatient medical care and consultations.

   Benefits are available for the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the Member at a site other than the site where the Member is located ("Telemedicine Services"). Benefits are available for services appropriately provided through Telemedicine Services, to the same extent as benefits provided for face-to-face consultation or contact between a Health Care Provider and a Member. Telemedicine Services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a Health Care Provider and a Member.

2. Support services including room and board in a semi-private room (or in a private room when Medically Necessary), and medical and nursing services provided to hospital patients in the course of care including services such as laboratory, radiology, pharmacy, Occupational Therapy, Physical Therapy, Speech Therapy, blood products (both derivatives and components) and whole blood, if not donated or replaced. See the Schedule of Benefits to determine if benefits are available for a private room and board for non-isolation purposes.

3. Surgery, as follows:

   a. Oral surgery, limited to:

      1) Surgery involving a bone, joint or soft tissue of the face, neck or head to treat a condition caused by disease, accidental injury and trauma, or congenital deformity not solely involving teeth.

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

      Coverage will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if:

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

      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. Medically Necessary surgical procedures, as determined by CareFirst.

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

      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 Evidence of Coverage based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.

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 Evidence of Coverage based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.

c. 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.

4. Inpatient/outpatient assistant if the surgery requires surgical assistance as determined by CareFirst.

5. Inpatient/outpatient anesthesia services by a Health Care Provider other than the operating surgeon.

6. Inpatient/outpatient chemotherapy.

7. Home Infusion Therapy.

8. Inpatient/outpatient radiation therapy.

9. Inpatient/outpatient renal dialysis.

10. Inpatient/outpatient diagnostic and treatment services provided and billed by a Health Care Provider, including diagnostic procedures, laboratory tests and x-ray services, including electrocardiograms, electroencephalograms, tomography, laboratory services, diagnostic x-ray services, and diagnostic ultrasound services.

11. Administration of injectable Prescription Drugs by a Health Care Provider.

12. Outpatient acupuncture.

13. Allergy-related services, including: allergen immunotherapy (allergy injections), allergenic extracts (allergy sera), allergy testing.

14. Contraceptive exam, insertion and removal: benefits are available for the insertion or removal, and any Medically Necessary examination associated with the use of a contraceptive device/ Prescription Drug, approved by the FDA for use as a contraceptive, and prescribed by a Health Care Provider.

15. Cleft lip or cleft palate or both: inpatient or outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological and speech/language treatment for cleft lip or cleft palate or both.

16. Elective sterilization.

17. Procedures to reverse sterilization.

18. Skilled Nursing Facility services.

19. 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.

20. Treatment of temporomandibular joint (TMJ) dysfunction: Medically Necessary conservative treatment and surgery, as determined by CareFirst.

21. Family planning services, including contraceptive counseling.

MASTECTOMY-RELATED SERVICES

A. Covered Benefits

1. Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy;

2. Breast prostheses prescribed by a physician for a Member who has undergone a mastectomy and has not had breast reconstruction;

3. Physical complications from all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Member;

MATERNITY SERVICES AND NEWBORN CARE

A. Covered Services

1. Health Care Provider services including:

   a. Mother:

      1) Prenatal visits;

      2) Delivery of the child(ren);

      3) Postnatal visits.

   b. Newborn, if added within 31-day special enrollment period beginning on the date of birth:

      1) Medically Necessary services for the normal newborn (an infant born at approximately forty (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;

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

      3) Circumcision.

2. Inpatient hospital services in connection with childbirth, for the mother or newborn child(ren), including routine nursery care of the newborn child(ren), are available for:

   a. A minimum of:

      1) forty-eight (48) hours following an uncomplicated vaginal delivery;

      2) ninety-six (96) hours following an uncomplicated cesarean section.

   b. If newborn added within 31-day special enrollment period beginning on the date of birth, up to four additional days of routine nursery care of the newborn child(ren) when the Member is required to remain in the hospital for Medically Necessary reasons.

3. Elective abortions.

4. Coverage for victims of rape or incest.

5. Birthing centers.

6. Benefits are available for universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.

MEDICAL DEVICES AND SUPPLIES

A. Definitions

Durable Medical Equipment means equipment which:

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
7. Can withstand repeated use.

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.

Medical Device means Durable Medical Equipment, Hearing Aid, Medical Supplies, Orthotic Devices and Prosthetic Devices.

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.

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;
5. Include devices necessary for post-operative healing.

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.

B. Covered Services

1. **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.

2. **Hair Prosthesis**
Benefits are available for a hair prosthesis when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.

3. **Hearing Aids**
Covered Services for a minor Dependent child, as follows:

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

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

4. **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.

5. **Medical Supplies**
Benefits are available for Medical Supplies as such supplies are defined above.

6. **Orthotic Devices, Prosthetic Devices**
Benefits include:

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

b. 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

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

d. **Repairs**. Benefits for the repair, maintenance or replacement of a Medical Device require authorization or approval by CareFirst. Benefits are limited to:

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

2) Coverage of repair costs is limited to adjustment required by normal wear or by a change in the Member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the Medical Device.

3) Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family member are not covered.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT

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

ORGAN AND TISSUE TRANSPLANTS

A. Definitions

Related Services means services or supplies for, or related to organ/tissue transplant procedures, including, but not limited to: diagnostic services, inpatient/outpatient Health Care Provider services, Prescription Drugs, surgical services, Occupational Therapy, Physical Therapy, and Speech Therapy.

B. Recipient/Donor benefits

When Member is a:	Benefits are available for:
Recipient	Benefits are available for both the Member-recipient and the non-Member-donor.
Donor	The Member-donor, if the recipient has no benefits available for the Member- donor.

C. Covered Services

1. Medically Necessary, non-Experimental/Investigational solid organ transplant procedures and bone marrow or other non-solid organ transplant procedures, and Related Services;

2. Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant;

3. Immunosuppressant maintenance drugs when prescribed for a covered transplant;

4. Organ transplant procurement benefits for the recipient:

   a. Health services and supplies used by the surgical team to remove the donor organ;

   b. Travel of a hospital surgical team to and from a hospital (other than the organ transplant hospital) where the organ is to be removed from the donor;

   c. Transport and storage of the organ, at the organ transplant hospital, in accordance with approved practices.

5. Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant hospital is over fifty (50) miles from the recipient's home. Travel is limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. In order to receive travel benefits, a companion must be at least eighteen (18) years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under eighteen (18) years of age, there may be two companions.

D. Additional requirements
The organ transplant hospital must:

1. Have fair and practical rules for choosing recipients and a written contract with someone that has the legal right to procure donor organs;

2. Conform to all laws that apply to organ transplants;

3. Be approved by CareFirst.

At least thirty (30) days before the start of a planned organ transplant the recipient's physician must give CareFirst written notice including:

1. Proof of Medical Necessity;

2. Diagnosis;

3. Type of surgery;

4. Prescribed treatment.

OUTPATIENT PRIVATE DUTY NURSING

Benefits are available for Medically Necessary outpatient Private Duty Nursing, as determined by CareFirst. Benefits are not provided for Private Duty Nursing rendered in a hospital.

PRESCRIPTION DRUGS

Benefits for Prescription Drugs, intended for outpatient use, include injectable Prescription Drugs that require administration by a Health Care Provider. Additional benefits for Prescription Drugs, intended for outpatient use, are available as follows:

Pharmacy-dispensed Prescription Drugs	Prescription Drugs dispensed in the office of a Health Care Provider
Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs.	Benefits are available, and limited to, Prescription Drugs dispensed in the office of a Health Care Provider. **Contraceptives**: Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.

REHABILITATIVE AND HABILITATIVE SERVICES

A. Covered Services

1. **Inpatient Rehabilitative Services**
   Benefits are available for inpatient Rehabilitative Services.

2. **Outpatient Rehabilitative Services**
   Benefits are available for the following outpatient Rehabilitative Services:

   a. Occupational Therapy;

   b. Physical Therapy; and

   c. Speech Therapy.

3. **Cardiac Rehabilitation**
   Benefits for Cardiac Rehabilitation are provided to a Member who has been diagnosed with significant cardiac disease, as defined by CareFirst, or, who, immediately preceding referral for Cardiac Rehabilitation, suffered a myocardial infarction or has undergone invasive cardiac treatment, as defined by CareFirst. All services must be Medically Necessary as determined by CareFirst in order to be covered. Services must be provided at a CareFirst-approved place of service equipped and approved to provide Cardiac Rehabilitation.

   Benefits will not be provided for maintenance programs.

4. **Habilitative Services (Dependent child under the age of 19)**
   Benefits are available for 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 to 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, cerebral palsy, intellectual disability, Down syndrome, spina bifida, hydroencephalocele, and congenital or genetic developmental disability.

SURGICAL TREATMENT OF MORBID OBESITY

A. Definitions

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

Morbid Obesity means:

1. A body mass index that is greater than forty (40) kilograms per meter squared; or

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

NIH means the National Institutes of Health.

B. Covered Services

Benefits are provided for the surgical treatment of Morbid Obesity. The procedures must be recognized by the NIH as effective for the long-term reversal of Morbid Obesity and consistent with guidelines approved by the NIH and deemed Medically Necessary by CareFirst.

EXCLUSIONS

This section lists services or conditions for which benefits are not available under this Evidence of Coverage.

CareFirst will not provide a benefit 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.

- Any mental health and substance use disorder services not rendered by the mental health and substance use administrator.

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

- Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons.

  This exclusion does not apply to:

  1. Medicaid;

  2. Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland;

  3. Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.

- 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.

- Routine dental care such as services, supplies, or charges directly related to the care, restoration, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.

- Cosmetic services (except for Mastectomy—Related Services and services for cleft lip or cleft palate or both).

- 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.

- All non-prescription drugs, medications, and biologicals, routinely obtained and self-administered by the Member, unless otherwise a Covered Service.

- All Over-the-Counter items and supplies, routinely obtained and self-administered by the Member including, but not limited to: non-prescription eye wear; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and Over-the-Counter solutions, except as stated in the Description of Covered Services

- All Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services.
- Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- Lifestyle improvements, including, but not limited to smoking cessation, health education classes and self-help programs, except as stated in the Description of Covered Services.
- Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment.
- Treatment for weight reduction and obesity except for the surgical treatment of Morbid Obesity.
- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- Services furnished as a result of a referral prohibited by law.
- Any recreational activity intended as a rehabilitative service. This includes, but is not limited to: sports, games, horseback riding, and athletic training, even though such services may have therapeutic value or be provided by a Health Care Provider.
- 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.

    2. 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 Evidence of Coverage are limited to Covered Services rendered to a Member by a Health Care Provider.

- Educational therapies intended to improve academic performance.
- Vocational rehabilitation and employment counseling.
- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services) except General Anesthesia & Associated Hospital or Ambulatory Surgical Facility Services for Dental Care.
- Separate billings for health care services or supplies furnished by an employee of a Health Care Provider which are normally included in the Health Care Provider's charges and billed for by them.
- Services that are non-medical in nature, including, but not limited to personal hygiene, Cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.
- Personal comfort items, even when used by a member in an inpatient hospital setting, such as telephones, televisions, guest trays, or laundry charges.
- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living; e.g., bathing, toileting, and eating (care which may be provided by persons without professional medical skills or training).

- Self-care or self-help training designed to enable a member to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated.
- Services intended to increase the intelligence quotient (IQ) of Members with an intellectual disability or to provide cure for primary developmental disabilities, if such services do not fall within generally accepted standards of medical care.
- Services for the purpose of controlling or overcoming delinquent, criminal, or socially unacceptable behavior unless deemed Medically Necessary by CareFirst.
- Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related.
- Services related to human reproduction other than specifically described in this Evidence of Coverage including, but not limited to maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a Member.
- Blood products and whole blood when donated or replaced.
- Oral surgery, dentistry or dental processes unless otherwise stated, including removal or replacement of teeth, crowns, bridges, implants, orthodontics except cleft palate, the operation or treatment for the fitting or wearing of dentures, periodontal therapy, direct or indirect restorations (fillings) root canal therapy, treatment of dental cysts and abscesses.
- Premarital exams.
- Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.
- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.
- Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust, or a similar entity.
- Services rendered or available under any Workers' Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a Member is exempt from the above laws, the benefits of this Evidence of Coverage will be provided for Covered Services.
- Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain.
- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- Services required solely for administrative purposes, like employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
- Immunizations solely for foreign travel.
- Charges used to satisfy a Member's dental care, Prescription Drug, or vision care benefits deductible, if applicable, or balances from any such programs.

- Financial and/or legal services.
- Dietary or nutritional counseling, except as stated in the Description of Covered Services.
- Hearing care except as otherwise stated.
- Tinnitus maskers, purchase, examination, or fitting of Hearing Aids except as stated in the Description of Covered Services, Medical Devices and Supplies, Hearing Aids. Hearing care benefits for an adult Member may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
- Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
- Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst.
- 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.

The following exclusions are specific to the corresponding services listed in the Description of Covered Services.

CareFirst will not provide a benefit for:

Emergency Services

- Except for covered ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

General anesthesia and associated hospital or ambulatory surgical facility services for dental care

- Dental care for which general anesthesia is provided.

Home Health Care

- Rental or purchase of renal dialysis equipment and supplies.
- "Meals-on-Wheels" type food plans.
- Domestic or housekeeping services.
- Care that, after training by skilled personnel, can be rendered by a non-Health Care Provider, such as one of the Member's family or a friend (changing dressings for a wound is an example of such care).

Hospice care

- Any services other than palliative treatment.
- Rental or purchase of renal dialysis equipment and supplies.
- Domestic or housekeeping services.
- "Meals on Wheels" or similar food arrangements.

Infertility services

- 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:

    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.

- Services for the collection of sperm for artificial insemination, except when the male donor is also a Member.

- When any surrogate or gestational carrier is used.

- When the service involves the use of donor egg(s), donor embryo(s).

- When the service involves the participation of a common law spouse, except in states that recognize the legality of those relationships.

- Self-administered fertility drugs; however, coverage will be provided for self-administered in-vitro fertilization Prescription Drugs if the Group does not otherwise provide Prescription Drug benefits.

Additionally, Infertility services benefits do not include benefits for cryopreservation, storage, and or thawing of sperm, egg(s), or embryo(s).

Inpatient/outpatient Health Care Provider services

- Medical care for inpatient stays that are primarily for any diagnostic service and/or observation.

- Medical care for inpatient stays that are primarily for Rehabilitative Services, except as stated in the Description of Covered Services.

- A private room, when the hospital has semi-private rooms (CareFirst will base payment on the average semi-private room rate).

- Inpatient Private Duty Nursing.

- Surgical removal of impacted teeth.

Medical Devices and Supplies

- Cranial molding orthoses for positional/deformational/non-synostotic plagiocephaly or brachycephaly.

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

- Food and formula consumed as sole source or supplemental nutrition, except as stated in the Description of Covered Services.

Mental health and substance use disorder services, including behavioral health treatment

- Marital counseling.

- Wilderness programs.
- Boarding schools.

Organ and tissue transplants

- Any and all services for or related to any organ transplants except those deemed Medically Necessary and non-Experimental/Investigational by CareFirst.
- Any organ transplant or procurement done outside the continental United States.
- An organ transplant relating to a condition arising from and in the course of employment.
- Organ and tissue transplant Covered Services if there are research funds to pay for the Covered Services.
- Expenses Incurred for the location of a suitable donor; e.g., search of a population or mass screening.

Prescription Drugs

- Outpatient Prescription Drugs, except as stated in the Description of Covered Services. Additional Prescription Drug benefits for a Member may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
- Routine immunizations and boosters (see Description of Covered Services, Preventive and Wellness Services)

Rehabilitative and Habilitative Services

- Habilitative Services for a Member 19 years and older.

ELIGIBILITY SCHEDULE

ELIGIBILITY		
The following persons meeting the eligibility requirements established by the Group are eligible for benefits under this Evidence of Coverage:		
Subscriber	A person eligible under guidelines defined by the Group including Medicare-eligible retiree under the terms of the Group's retirement program, as amended from time to time who was covered as a wage-earning employee before retirement.	
Spouse	Coverage for a Dependent spouse is available.	
Domestic Partner	Coverage for a Domestic Partner, including a Medicare-eligible Domestic Partner, is available.	
Dependent children	Coverage for Dependent children, including children of a Domestic Partner, is available.	**Limiting Age** Up to age 26
Unmarried incapacitated Dependent children	A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if: 1. The Dependent child is chiefly dependent for support upon the Subscriber or the Subscriber's Dependent spouse; and 2. At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age. 3. The Subscriber provides the Group (or CareFirst if the Group so elects) with proof of the Dependent child's mental or physical incapacity within thirty-one (31) days after the Dependent child's coverage would otherwise terminate. The Group has the right to determine whether the child is and continues to qualify as mentally or physically incapacitated.	**Limiting Age** Not applicable
Individuals covered under prior continuation provision	Coverage for a person whose coverage was being continued under a continuation provision of the Group's prior health insurance plan is available.	
	Coverage for a person whose coverage was being continued under a continuation provision of the Subscriber's prior health insurance plan is available.	

EFFECTIVE DATES	
Open Enrollment	The Group's Contract Date
Newly eligible Subscriber	A newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group. A Subscriber who is not enrolled when the Group receives a QMSO is eligible for coverage effective on the date specified in the MCSO.
Dependents of a newly eligible Subscriber	Dependents of a newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.
Individuals whose coverage was being continued under the Group's prior health insurance plan	The Group's Contract Date
Dependents of the individual being continued under the individual's prior health insurance plan	An individual will be effective as stated in "Dependents of a newly eligible Subscriber."

SPECIAL ENROLLMENT PERIODS	
Special enrollment for certain individuals who lose coverage (not applicable to retirees, if retirees are eligible for coverage)	The employee must notify the Group, and the Group must notify CareFirst no later than thirty (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 thirty (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) is effective on the first of the month following acceptance of the enrollment by CareFirst.
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. A new Subscriber and/or his/her Dependents is 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.
Special enrollment regarding Medicaid and CHIP termination or eligibility	The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act. The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan). A new Subscriber and/or his/her dependents are effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.

TERMINATION OF COVERAGE	
Subscriber no longer eligible	A Subscriber and his/her Dependents will remain covered until the end of the month the Subscriber's eligibility ceases as determined by the Group.
Dependent child	A Dependent child will remain covered until the end of the month when eligibility ceases as determined by the Group.
Dependent spouse no longer eligible	A Dependent spouse will remain covered until the end of the month eligibility ceases as determined by the Group.
Nonpayment by the Group	Coverage will terminate on the date stated in CareFirst's written notice of termination.
Fraud or intentional misrepresentation of material fact	Coverage will terminate on the date stated in CareFirst's and/or the Group's written notice of termination.
Subscriber changes the Type of Coverage to an Individual or other non-family contract (except in the case of a Dependent child enrolled pursuant to a court or administrative order or QMSO)	Coverage will terminate at the end of the month the Subscriber changes the Type of Coverage to an Individual or other non-family contract.
Death of a Subscriber	Coverage of any Dependents will terminate on the date determined by the Group.

SCHEDULE OF BENEFITS - HIGH OPTION

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment.

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

CareFirst has designed the below Schedule of Benefits to identify CareFirst's payment for Covered Services. Such payments typically depend on:

Type of Health Care Provider (e.g., hospital/facility vs. professional practitioner);

Covered Service(s); and

Place of service (e.g., inpatient/outpatient, emergency room/department, hospital/facility, office).

Generally, services rendered in a hospital/facility place of service result in claims both from the hospital/facility and from professional practitioners rendering care in the hospital/facility setting.

Additionally, certain Covered Services may result in claims for multiple services. For example, claims for mastectomy-related services could include, at minimum, diagnostic services and surgery. Instead of repeating the CareFirst Payment for diagnostic services and surgery, the CareFirst payment for mastectomy-related services indicates "Benefits are available to the same extent as benefits provided for other illnesses."

Unless otherwise stated for a particular Covered Service during a Benefit Period, including, as applicable, Covered Services under any attached riders:

DEDUCTIBLE: Out-of-Network Only		
Individual	**Family**	
$300	$600	
Deductible applicable to out-of-network Covered Services, except as stated in the Schedule of Benefits.		
The Deductible is calculated based on the Allowed Benefit of Covered Services.		
The family Deductible amount is calculated in the aggregate. CareFirst pays benefits for a family Member in a family Type of Coverage who reaches the individual Deductible amount before the family Deductible amount is reached. A family Member may not contribute more than the individual Deductible amount to the family Deductible amount.		
The following amounts are included/excluded from the Deductible:	**Included**	**Excluded**
Amounts in excess of the Allowed Benefit	No	Yes
Copays	No	Yes

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.

OUT-OF-POCKET MAXIMUM			
In-Network		**Out-of-Network**	
Individual	Family	Individual	Family
$1,000	$2,000	$2,000	$4,000

In-Network and Out-of-Network		
The in-network and out-of-network Out-of-Pocket Maximum will be a combined amount.		
The family Out-of-Pocket Maximum is calculated in the aggregate. A family Member may not contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.		
CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Out-of-Pocket Maximum is met; however, Copays will continue to apply.		
The following amounts are included/excluded from the Out-of-Pocket Maximum:	**Included**	**Excluded**
Amounts in excess of the Allowed Benefit	No	Yes
Deductible	Yes	No
Coinsurance (Member's share)	Yes	No
Copays	No	Yes

LIFETIME MAXIMUM
The Lifetime Maximum for Essential Health Benefits Covered Services and for Covered Services that are **not** Essential Health Benefits is unlimited per Member.
This Lifetime Maximum creates no rights to benefits after a Member loses entitlement to coverage or is no longer covered under the Group Contract.

IMPORTANT NOTE REGARDING THE ALLOWED BENEFIT FOR CERTAIN PROVIDERS
The Allowed Benefit will be the provider's actual charge for the following Health Care Providers:
• Anesthesiologist • Pathologist • Radiologist • Surgical assistants

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Preventive and wellness services		The CareFirst payment for preventive care Covered Services is separate from the CareFirst payment for Covered Services to treat an illness/injury. Benefits for Covered Services to treat a condition diagnosed during a preventive care visit are available to the same extent as benefits provided for other illnesses.	
Child wellness			
Office visits	No	No Deductible required 100% of Allowed Benefit after $10 Copay	No Deductible required 80% of Allowed Benefit
Immunizations (except yellow fever immunization)	No	No Deductible required 100% of Allowed Benefit	
Yellow fever immunization	No	No Deductible required 100% of Allowed Benefit after $15 Copay	
Diagnostic services	Yes		
Hospital		No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Outpatient professional practitioner		No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Office		No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Universal hearing screening of newborns	No	Benefits are available to the same extent as benefits provided for inpatient/outpatient Health Care Provider services	
Human papillomavirus screening	Yes	Benefits are available to the same extent as benefits provided for diagnostic services	
Colorectal cancer screening	Yes: diagnostic services No: surgery	Benefits are available to the same extent as benefits provided for diagnostic services and surgery	
Mammography/breast cancer screening	Yes	Benefits are available to the same extent as benefits provided for diagnostic services	
Osteoporosis prevention	Yes	Benefits are available to the same extent as benefits provided for diagnostic services	
Prostate cancer screening	Yes: diagnostic services No: outpatient medical care	Benefits are available to the same extent as benefits provided for outpatient medical care and diagnostic services	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Preventive and wellness services		The CareFirst payment for preventive care Covered Services is separate from the CareFirst payment for Covered Services to treat an illness/injury. Benefits for Covered Services to treat a condition diagnosed during a preventive care visit are available to the same extent as benefits provided for other illnesses..	
Routine gynecological (GYN) exam	Yes (Preferred Provider only)	**Limitations** Benefits for routine gynecological (GYN) exam are limited to one visit per Benefit Period.	
		No Deductible required 100% of Allowed Benefit after $10 Copay	No Deductible required 80% of Allowed Benefit
Pap smear	Yes	No Deductible required 100% of Allowed Benefit after $10 Copay	No Deductible required 80% of Allowed Benefit
Routine physical exam	Yes: diagnostic services No: outpatient medical care	**Limitations** Benefits for routine physical exam are limited to one visit per Benefit Period.	
		No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Ambulance Services		**Limitations** Ambulance services are limited, as follows: • Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance.	
Emergency Ambulance Services	Yes	No Deductible required 100% of Allowed Benefit*	
Non Emergency Ambulance Services		No Deductible required 100% of Allowed Benefit**	

*The Allowed Benefit for Out-of-Network Emergency Ambulance Services will be the provider's actual charge.
**The Allowed Benefit for Out-of-Network Non-Emergency Ambulance Services will be as defined in the Definitions section of this Evidence of Coverage.

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Controlled Clinical Trials Patient Costs	Same as applicable Covered Services	**Limitations** Hospital Pre-Certification and Review and an approved Plan of Treatment is required.	
		Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Diabetes equipment, supplies, and self-management training	Yes (Medical Supplies) No (outpatient medical care)	Benefits are available to the same extent as benefits provided for Medical Supplies and outpatient medical care.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Emergency Services			
Emergency Services in a hospital emergency room/department		**Limitations** Treatment for Emergency Services must begin within 72 hours.	
Hospital emergency room/ department and ancillary services routinely available to the emergency room/department	Yes	No Deductible required 100% of Allowed Benefit after $25 Copay *	
Outpatient professional practitioner(s) in hospital emergency room/department	Yes	No Deductible required 100% of Allowed Benefit	
Member admitted as inpatient	Same as applicable Covered Services	Benefits are available to the same extent as other Inpatient Health Care Provider services.	
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department			
Office	Yes	No Deductible required 100% of Allowed Benefit after $10 Copay	
Dental services related to accidental injury or trauma	Yes	No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit

*Copay waived if admitted

Covered Service	CareFirst Payment
General anesthesia and associated hospital or ambulatory surgical facility services for dental care	
	Benefits are available to the same extent as benefits provided for other illnesses.

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Home Health Care		**Limitations** An approved Plan of Treatment is required for Home Health Care. Hospital/home health agency: Ninety (90) days of unlimited Home Health Care Visits.	
Hospital/home health agency	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Home visits following childbirth	Yes	Home Health Care Visit limits, if applicable, do not apply.	
		No Deductible required 100% of Allowed Benefit	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Hospice care		**Limitations** An approved Plan of Treatment is required for hospice care; the Plan of Treatment must be accepted in writing by the Member and or family. There must be a willing and able Caregiver available. Respite Care is limited to a maximum of fourteen (14) days per Benefit Period. At the discretion of CareFirst, Respite Care may be limited to five (5) consecutive days for each inpatient stay.	
Facility/agency	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Respite care	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Infertility services			
Artificial insemination (AI)/ intrauterine insemination (IUI)	Same as applicable Covered Services	**Limitations** An approved Plan of Treatment is required. Benefits for artificial insemination (AI) and/or intrauterine insemination (IUI) are limited to six (6) attempts per live birth.	
		Benefits are available to the same extent as benefits provided for other illnesses.	
In vitro fertilization (IVF)	Same as applicable Covered Services	**Limitations** An approved Plan of Treatment is required. Benefits for in vitro fertilization (IVF) are limited to three attempts per live birth; and a lifetime maximum benefit of $100,000. This maximum in no way creates a right to benefits after termination.	
		Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Inpatient Health Care Provider Services		Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient hospital or health care facility	No	**Limitations** Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Skilled Nursing Facility	No	**Limitations** Hospital Pre-Certification and Review is required. Skilled Nursing Facility services are limited to 100 days per Benefit Period.	
		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery (except radiologists, pathologists, anesthesiologists, and surgical assistants)	No	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Radiologist, pathologist, anesthesiologist, surgical assistant		No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit*

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Inpatient/Outpatient Health Care Provider Services			
Contraceptive exam, insertion and removal	Same as applicable Covered Services	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	
Cleft lip or cleft palate, or both			
Orthodontics, oral surgery	No (for orthodontic services) Yes (for oral surgery provided by Contracted Provider in office only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Otological, audiological and speech/language treatment		Rehabilitative Services visit limits for Speech Therapy, if applicable, do not apply.	
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Maternity services and newborn care			
Maternity services and newborn care	Yes (Contracted Provider only)	Benefits are available to the same extent as benefits provided for other illnesses. *Copay is taken on initial office visit only	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Medical Devices and Supplies			
Durable Medical Equipment	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Hair prosthesis	Yes	**Limitation** Benefits are limited to one (1) hair prosthesis per Benefit Period.	
		No Deductible required 100% of the Allowed Benefit up to $350	
Hearing Aids for a minor Dependent child	No	**Limitations** Benefits are limited to minor Dependent children.	
		No Deductible required 100% of the Allowed Benefit every thirty-six (36) months for one Hearing Aid for each hearing-impaired ear	
Non-routine services related to the Hearing Aid dispensing		Benefits are available to the same extent as benefits provided for other illnesses.	
Medical foods and nutritional substances	Yes	Benefits are available to the same extent as benefit provided for Medical Supplies.	
Medical Supplies	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Orthotic Devices; Prosthetic Devices, leg, arm, eye	No	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	**Out-of-Network**
Mental health and substance use disorder services, including behavioral health treatment		Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient Health Care Provider Services	No	**Limitations** Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
		Benefits are available to the same extent as Inpatient Health Care Provider services benefits provided for other illnesses.	
Outpatient Health Care Provider Services (except outpatient methadone maintenance treatment)	No	Benefits for outpatient care are available, including: • Partial hospitalization; • psychological and neuropsychological testing for diagnostic purposes; and • visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy.	
Hospital		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office		No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit
Outpatient methadone maintenance treatment	No	**Limitations** Member payment for methadone maintenance will not be greater than 50% of its daily cost.	
Hospital		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office		No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit
Emergency Services	Yes	Benefits are available to the same extent as Emergency Services benefits for other illnesses.	
Prescription Drugs	Not Applicable	Benefits are available to the same extent as Prescription Drug benefits for other illnesses.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Non-Preventive Outpatient Diagnostic Services except CAT scans, MRI's, holter monitors			
Hospital	Yes	No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Outpatient professional practitioner	Yes	No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Office	Yes	No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
CAT scans, MRI's, holter monitors			
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Organ and tissue transplants		**Limitations** Benefits are limited to the extent stated in the Organ and Tissue Transplant subsection of the Description of Covered Services.	
Organ and tissue transplants	Same as applicable Covered Services	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant procurement			
Organ transplant travel			

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Health Care Provider Services			
Medical care and consultations (illness visits, except non-routine ophthalmology)	No		
Outpatient hospital/facility		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office		No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit
Retail Health Clinic		No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit
Ophthalmology (non-routine services)	Yes (Contracted Provider in office setting only)	No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Health Care Provider Services			
Outpatient Surgical Services			
Surgery (except oral surgery rendered by a Contracted Provider in an office)	No	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Oral Surgery	Yes (Contracted Provider in office setting only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Anesthesia	Same as applicable Covered Services	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Surgical assistant	Same as applicable Covered Services	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Elective sterilization	Same as applicable Covered Services	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Health Care Provider Services			
Outpatient Surgical Services			
Procedures to reverse sterilization	Same as applicable Covered Services	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Health Care Provider Services			
Acupuncture	No		
Office		No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit
Administration of injectable Prescription Drugs	No	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Allergen immunotherapy (allergy injections) excluding the allergenic extracts (sera)	No	No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit
Allergenic extracts (sera)	No	Benefits for allergy sera are available to the same extent as benefits provided for Prescription Drugs	
Allergy testing	No	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Chemotherapy		Additional services directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an oncologist are also Direct Access Services.	
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Home Infusion Therapy	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Inhalation therapy			
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Health Care Provider Services			
Office	Yes (Contracted Provider in office setting only)	No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit
Photochemotherapy		Additional services directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an oncologist are also Direct Access Services.	
Office	Yes	No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit
Radiation therapy		Additional services directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an oncologist are also Direct Access Services.	
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Renal dialysis			
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider in office setting only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit
Spinal manipulation	No		
Office		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Vision therapy (orthoptics/pleoptics)	No		
Office		No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Private Duty Nursing	No	**Limitations** An approved Plan of Treatment is required. No inpatient Private Duty Nursing services are available.	
Facility/agency		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Prescription Drugs	Same as applicable Covered Services	**Limitations** Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits available through CareFirst for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.	
Prescription Drugs		Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drugs that require administration by a Health Care Provider		Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drug contraceptives and contraceptive devices		Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	Direct Access Services	CareFirst Payment	
		In-Network	Out-of-Network
Rehabilitative and Habilitative Services			
Inpatient Rehabilitative Services	No	**Limitations** Hospital Pre-Certification and Review is required. Benefits are available to the same extent as inpatient benefits provided for other illnesses.	
Outpatient Rehabilitative Services		**Limitations** An approved Plan of Treatment is required for Habilitative Services. **In-Network** Limited to 90 visits per Benefit Period: Occupational Therapy Limited to 90 visits per Benefit Period: Physical Therapy Limited to 90 visits per Benefit Period: Speech Therapy **Out-of-Network** **V**isit limit does not apply: Occupational Therapy, Physical Therapy, Speech Therapy. Visit limit does not apply to Habilitative Services Covered Services. Visit limit does not apply to otological, audiological and speech/language treatment for cleft lip or cleft palate, or both.	
Occupational Therapy			
Hospital/facility	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Physical Therapy			
Hospital/facility	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Speech Therapy			
Hospital/facility	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Services	CareFirst Payment	
		In-Network	Out-of-Network
Rehabilitative and Habilitative Services			
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Cardiac Rehabilitation	No	**Limitations** **In-Network** Cardiac rehabilitation limited to 90 visits per Benefit Period. **Out-of-Network** Visit limit does not apply.	
Hospital/facility		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Habilitative Services	Same as applicable Covered Services	**Limitations** An approved Plan of Treatment is required for Habilitative Services. Benefits are available for Dependent children under nineteen (19) years old. Outpatient rehabilitative services visit limits, if applicable, do not apply to Habilitative Services Covered Services.	
		Benefits are available to the same extent as benefits provided for other outpatient services.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Surgical treatment of Morbid Obesity	Same as applicable Covered Services	**Limitations** Benefits are limited to the extent stated in the Description of Covered Services.	
		Benefits are available to the same extent as surgical benefits provided for other illnesses.	

SCHEDULE OF BENEFITS - STANDARD OPTION

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment.

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

CareFirst has designed the below Schedule of Benefits to identify CareFirst's payment for Covered Services. Such payments typically depend on:

Type of Health Care Provider (e.g., hospital/facility vs. professional practitioner);

Covered Service(s); and

Place of service (e.g., inpatient/outpatient, emergency room/department, hospital/facility, office).

Generally, services rendered in a hospital/facility place of service result in claims both from the hospital/facility and from professional practitioners rendering care in the hospital/facility setting.

Additionally, certain Covered Services may result in claims for multiple services. For example, claims for mastectomy-related services could include, at minimum, diagnostic services and surgery. Instead of repeating the CareFirst Payment for diagnostic services and surgery, the CareFirst payment for mastectomy-related services indicates "Benefits are available to the same extent as benefits provided for other illnesses."

Unless otherwise stated for a particular Covered Service during a Benefit Period, including, as applicable, Covered Services under any attached riders:

COPAYS	
Primary Care Provider (PCP)	**Specialist**
A $15 per visit Copay applies to Covered Services by a provider with a specialty of: Family Practice General Practice Internal Medicine Pediatrics	A $30 per visit Copay applies to Covered Services by all other practitioners.

INPATIENT COPAY: In-Network
$150
The inpatient Copay applies to any admission, except Skilled Nursing Facility

DEDUCTIBLE: Out-of-Network Only		
Individual	**Family**	
$300	$600	
Deductible applicable to out-of-network Covered Services, except as stated in the Schedule of Benefits.		
The Deductible is calculated based on the Allowed Benefit of Covered Services.		
The family Deductible amount is calculated in the aggregate. CareFirst pays benefits for a family Member in a family Type of Coverage who reaches the individual Deductible amount before the family Deductible amount is reached. A family Member may not contribute more than the individual Deductible amount to the family Deductible amount.		
The following amounts are included/excluded from the Deductible:	**Included**	**Excluded**
Amounts in excess of the Allowed Benefit	No	Yes
Inpatient Copay	No	Yes
Copays	No	Yes

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.

OUT-OF-POCKET MAXIMUM			
In-Network		**Out-of-Network**	
Individual	Family	Individual	Family
$1,000	$2,000	$2,000	$4,000

In-Network and Out-of-Network		
The in-network and out-of-network Out-of-Pocket Maximum will be a combined amount.		
The family Out-of-Pocket Maximum is calculated in the aggregate. A family Member may not contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.		
CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Out-of-Pocket Maximum is met; however, Copays will continue to apply.		
The following amounts are included/excluded from the Out-of-Pocket Maximum:	**Included**	**Excluded**
Amounts in excess of the Allowed Benefit	No	Yes
Deductible	Yes	No
Inpatient Copay	Yes	No
Coinsurance (Member's share)	Yes	No
Copays	No	Yes

LIFETIME MAXIMUM
The Lifetime Maximum for Essential Health Benefits Covered Services and for Covered Services that are **not** Essential Health Benefits is unlimited per Member.
This Lifetime Maximum creates no rights to benefits after a Member loses entitlement to coverage or is no longer covered under the Group Contract.

IMPORTANT NOTE REGARDING THE ALLOWED BENEFIT FOR CERTAIN PROVIDERS
The Allowed Benefit will be the provider's actual charge for the following Health Care Providers:
• Anesthesiologist • Pathologist • Radiologist • Surgical assistants

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Preventive and wellness services		The CareFirst payment for preventive care Covered Services is separate from the CareFirst payment for Covered Services to treat an illness/injury. Benefits for Covered Services to treat a condition diagnosed during a preventive care visit are available to the same extent as benefits provided for other illnesses.	
Child wellness			
Office visits	No	No Deductible required 100% of Allowed Benefit after $15 PCP Copay or $30 Specialist Copay	No Deductible required 80% of Allowed Benefit
Immunizations (except yellow fever immunization)	No	No Deductible required 100% of Allowed Benefit	
Yellow fever immunization	No	No Deductible required 100% of Allowed Benefit after $15 PCP Copay	
Diagnostic services	Yes		
Hospital		No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Outpatient professional practitioner		No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Office		No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Universal hearing screening of newborns	No	Benefits are available to the same extent as benefits provided for inpatient/outpatient Health Care Provider services	
Human papillomavirus screening	Yes	Benefits are available to the same extent as benefits provided for diagnostic services	
Colorectal cancer screening	Yes: diagnostic services No: surgery	Benefits are available to the same extent as benefits provided for diagnostic services and surgery	
Mammography/breast cancer screening	Yes	Benefits are available to the same extent as benefits provided for diagnostic services	
Osteoporosis prevention	Yes	Benefits are available to the same extent as benefits provided for diagnostic services	
Prostate cancer screening	Yes: diagnostic services No: outpatient medical care	Benefits are available to the same extent as benefits provided for outpatient medical care and diagnostic services	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Preventive and wellness services		The CareFirst payment for preventive care Covered Services is separate from the CareFirst payment for Covered Services to treat an illness/injury. Benefits for Covered Services to treat a condition diagnosed during a preventive care visit are available to the same extent as benefits provided for other illnesses..	
Routine gynecological (GYN) exam	Yes (Preferred Provider only)	**Limitations** Benefits for routine gynecological (GYN) exam are limited to one visit per Benefit Period.	
		No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Pap smear	Yes	No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Routine physical exam	Yes: diagnostic services No: outpatient medical care	**Limitations** Benefits for routine physical exam are limited to one visit per Benefit Period.	
		No Deductible required 100% of Allowed Benefit after $15 PCP Copay or $30 Specialist Copay	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Ambulance Services		**Limitations** Ambulance services are limited, as follows: • Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance.	
Emergency Ambulance Services	Yes	No Deductible required 100% of Allowed Benefit*	
Non Emergency Ambulance Services		No Deductible required 100% of Allowed Benefit**	

*The Allowed Benefit for Out-of-Network Emergency Ambulance Services will be the provider's actual charge.
**The Allowed Benefit for Out-of-Network Non-Emergency Ambulance Services will be as defined in the Definitions section of this Evidence of Coverage.

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Controlled Clinical Trials Patient Costs	Same as applicable Covered Services	**Limitations** Hospital Pre-Certification and Review and an approved Plan of Treatment is required.	
		Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Diabetes equipment, supplies, and self-management training	Yes (Medical Supplies) No (outpatient medical care)	Benefits are available to the same extent as benefits provided for Medical Supplies and outpatient medical care.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Emergency Services			
Emergency Services in a hospital emergency room/department		**Limitations** Treatment for Emergency Services must begin within 72 hours.	
Hospital emergency room/ department and ancillary services routinely available to the emergency room/department	Yes	No Deductible required 100% of Allowed Benefit after $35 Copay *	
Outpatient professional practitioner(s) in hospital emergency room/department	Yes	No Deductible required 100% of Allowed Benefit	
Member admitted as inpatient	Same as applicable Covered Services	Benefits are available to the same extent as other Inpatient Health Care Provider services.	
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department			
Office	Yes	No Deductible required 100% of Allowed Benefit after $15 PCP Copay or $30 Specialist Copay	
Dental services related to accidental injury or trauma	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

*Copay waived if admitted

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Home Health Care		**Limitations** An approved Plan of Treatment is required for Home Health Care. Hospital/home health agency: Ninety (90) days of unlimited Home Health Care Visits.	
Hospital/home health agency	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Home visits following childbirth	Yes	Home Health Care Visit limits, if applicable, do not apply.	
		No Deductible required 100% of Allowed Benefit	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Hospice care		**Limitations** An approved Plan of Treatment is required for hospice care; the Plan of Treatment must be accepted in writing by the Member and or family. There must be a willing and able Caregiver available. Respite Care is limited to a maximum of fourteen (14) days per Benefit Period. At the discretion of CareFirst, Respite Care may be limited to five (5) consecutive days for each inpatient stay.	
Facility/agency	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Respite care	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Infertility services			
Artificial insemination (AI)/ intrauterine insemination (IUI)	Same as applicable Covered Services	**Limitations** An approved Plan of Treatment is required. Benefits for artificial insemination (AI) and/or intrauterine insemination (IUI) are limited to six (6) attempts per live birth.	
		Benefits are available to the same extent as benefits provided for other illnesses.	
In vitro fertilization (IVF)	Same as applicable Covered Services	**Limitations** An approved Plan of Treatment is required. Benefits for in vitro fertilization (IVF) are limited to three attempts per live birth; and a lifetime maximum benefit of $100,000. This maximum in no way creates a right to benefits after termination.	
		Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Inpatient Health Care Provider Services		Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient hospital or health care facility	No	**Limitations** Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
		No Deductible required 100% of Allowed Benefit after $150 per admission Copay	80% of Allowed Benefit
Skilled Nursing Facility	No	**Limitations** Hospital Pre-Certification and Review is required. Skilled Nursing Facility services are limited to 100 days per Benefit Period.	
		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery (except radiologists, pathologists, anesthesiologists, and surgical assistants)	No	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Radiologist, pathologist, anesthesiologist, surgical assistant		No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit*

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Inpatient/Outpatient Health Care Provider Services			
Contraceptive exam, insertion and removal	Same as applicable Covered Services	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	
Cleft lip or cleft palate, or both			
Orthodontics, oral surgery	No (for orthodontic services) Yes (for oral surgery provided by Contracted Provider in office only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Otological, audiological and speech/language treatment		Rehabilitative Services visit limits for Speech Therapy, if applicable, do not apply.	
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit after $15 PCP Copay or $30 Specialist Copay	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Maternity services and newborn care			
Maternity services and newborn care	Yes (Contracted Provider only)	Benefits are available to the same extent as benefits provided for other illnesses. *Copay is taken on initial office visit only	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Medical Devices and Supplies			
Durable Medical Equipment	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Hair prosthesis	Yes	**Limitation** Benefits are limited to one (1) hair prosthesis per Benefit Period.	
		No Deductible required 100% of the Allowed Benefit up to $350	
Hearing Aids for a minor Dependent child	No	**Limitations** Benefits are limited to minor Dependent children.	
		No Deductible required 100% of the Allowed Benefit every thirty-six (36) months for one Hearing Aid for each hearing-impaired ear	
Non-routine services related to the Hearing Aid dispensing		Benefits are available to the same extent as benefits provided for other illnesses.	
Medical foods and nutritional substances	Yes	Benefits are available to the same extent as benefit provided for Medical Supplies.	
Medical Supplies	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Orthotic Devices; Prosthetic Devices, leg, arm, eye	No	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	**Out-of-Network**
Mental health and substance use disorder services, including behavioral health treatment		Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient Health Care Provider Services	No	**Limitations** Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
		Benefits are available to the same extent as Inpatient Health Care Provider services benefits provided for other illnesses.	
Outpatient Health Care Provider Services (except outpatient methadone maintenance treatment)	No	Benefits for outpatient care are available, including: • Partial hospitalization; • psychological and neuropsychological testing for diagnostic purposes; and • visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy.	
Hospital		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office		No Deductible required 100% of Allowed Benefit after $15 Copay	80% of Allowed Benefit
Outpatient methadone maintenance treatment	No	**Limitations** Member payment for methadone maintenance will not be greater than 50% of its daily cost.	
Hospital		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office		No Deductible required 100% of Allowed Benefit after $15 Copay	80% of Allowed Benefit
Emergency Services	Yes	Benefits are available to the same extent as Emergency Services benefits for other illnesses.	
Prescription Drugs	Not Applicable	Benefits are available to the same extent as Prescription Drug benefits for other illnesses.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Non-Preventive Outpatient Diagnostic Services except CAT scans, MRI's, holter monitors			
Hospital	Yes	No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Outpatient professional practitioner	Yes	No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Office	Yes	No Deductible required 100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
CAT scans, MRI's, holter monitors			
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Organ and tissue transplants		**Limitations** Benefits are limited to the extent stated in the Organ and Tissue Transplant subsection of the Description of Covered Services.	
Organ and tissue transplants	Same as applicable Covered Services	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant procurement			
Organ transplant travel			

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Health Care Provider Services			
Medical care and consultations (illness visits, except non-routine ophthalmology)	No		
Outpatient hospital/facility		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office		No Deductible required 100% of Allowed Benefit after $15 PCP Copay or $30 Specialist Copay	80% of Allowed Benefit
Retail Health Clinic		No Deductible required 100% of Allowed Benefit after $15 Copay	80% of Allowed Benefit
Ophthalmology (non-routine services)	Yes (Contracted Provider in office setting only)	No Deductible required 100% of Allowed Benefit after $30 Copay	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Health Care Provider Services			
Outpatient Surgical Services			
Surgery (except oral surgery rendered by a Contracted Provider in an office)	No	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Oral Surgery	Yes (Contracted Provider in office setting only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Anesthesia	Same as applicable Covered Services	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Surgical assistant	Same as applicable Covered Services	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Elective sterilization	Same as applicable Covered Services	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	
Procedures to reverse sterilization	Same as applicable Covered Services	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Health Care Provider Services			
Acupuncture	No		
Office		No Deductible required 100% of Allowed Benefit after $10 Copay	80% of Allowed Benefit
Administration of injectable Prescription Drugs	No	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Allergen immunotherapy (allergy injections) excluding the allergenic extracts (sera)	No	No Deductible required 100% of Allowed Benefit after $5 Copay	80% of Allowed Benefit
Allergenic extracts (sera)	No	Benefits for allergy sera are available to the same extent as benefits provided for Prescription Drugs	
Allergy testing	No	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Health Care Provider Services			
Chemotherapy		Additional services directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an oncologist are also Direct Access Services.	
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Home Infusion Therapy	Yes	No Deductible required 100% of Allowed Benefit after $15 PCP Copay or $30 Specialist Copay	80% of Allowed Benefit
Inhalation therapy			
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider in office setting only)	No Deductible required 100% of Allowed Benefit after $15 PCP Copay or $30 Specialist Copay	80% of Allowed Benefit
Photochemotherapy		Additional services directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an oncologist are also Direct Access Services.	
Office	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Radiation therapy		Additional services directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an oncologist are also Direct Access Services.	
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Renal dialysis			

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Health Care Provider Services			
Hospital	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider in office setting only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit after $15 PCP Copay or $30 Specialist Copay	80% of Allowed Benefit
Spinal manipulation	No		
Office		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Vision therapy (orthoptics/pleoptics)	No		
Office		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Outpatient Private Duty Nursing	No	**Limitations** An approved Plan of Treatment is required. No inpatient Private Duty Nursing services are available.	
Facility/agency		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Prescription Drugs	Same as applicable Covered Services	**Limitations** Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits available through CareFirst for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.	
Prescription Drugs		Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drugs that require administration by a Health Care Provider		Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drug contraceptives and contraceptive devices		Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	Direct Access Services	CareFirst Payment	
		In-Network	Out-of-Network
Rehabilitative and Habilitative Services			
Inpatient Rehabilitative Services	No	**Limitations** Hospital Pre-Certification and Review is required. Benefits are available to the same extent as inpatient benefits provided for other illnesses.	
Outpatient Rehabilitative Services		**Limitations** An approved Plan of Treatment is required for Habilitative Services. **In-Network** Limited to 90 visits per Benefit Period: Occupational Therapy Limited to 90 visits per Benefit Period: Physical Therapy Limited to 90 visits per Benefit Period: Speech Therapy **Out-of-Network** **V**isit limit does not apply: Occupational Therapy, Physical Therapy, Speech Therapy. Visit limit does not apply to Habilitative Services Covered Services. Visit limit does not apply to otological, audiological and speech/language treatment for cleft lip or cleft palate, or both.	
Occupational Therapy			
Hospital/facility	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Physical Therapy			
Hospital/facility	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Speech Therapy			
Hospital/facility	Yes	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Direct Access Services	CareFirst Payment	
		In-Network	Out-of-Network
Rehabilitative and Habilitative Services			
Outpatient professional practitioner	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Office	Yes (Contracted Provider only)	No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Cardiac Rehabilitation	No	**Limitations** **In-Network** Cardiac rehabilitation limited to 90 visits per Benefit Period. **Out-of-Network: V**isit limit does not apply	
Hospital/facility		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		No Deductible required 100% of Allowed Benefit	80% of Allowed Benefit
Habilitative Services	Same as applicable Covered Services	**Limitations** An approved Plan of Treatment is required for Habilitative Services. Benefits are available for Dependent children under nineteen (19) years old. Outpatient rehabilitative services visit limits, if applicable, do not apply to Habilitative Services Covered Services.	
		Benefits are available to the same extent as benefits provided for other outpatient services.	

Covered Service	Direct Access Service	CareFirst Payment	
		In-Network	Out-of-Network
Surgical treatment of Morbid Obesity	Same as applicable Covered Services	**Limitations** Benefits are limited to the extent stated in the Description of Covered Services.	
		Benefits are available to the same extent as surgical benefits provided for other illnesses.	

CLAIMS PROCEDURES

A. SCOPE AND PURPOSE
B. CLAIMS PROCEDURES
C. CLAIMS PROCEDURES COMPLIANCE
D. CLAIM FOR BENEFITS
E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION
F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION
G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS
H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL
I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION OF APPEAL
J. DEFINITIONS

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 paragraph E.2., if a claim is wholly or partially denied, the Claimant shall be notified in accordance with paragraph 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 paragraph 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 paragraph 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 paragraph F. herein, and appeal shall be governed by paragraph 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 paragraph F. herein.

2) Post-Service Claims. In the case of a Post-Service Claim, the Claimant shall be notified, in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. 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 paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2.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 paragraph E.2.a. herein, provided that a written or electronic Notification in accordance with paragraph 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 paragraph 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 paragraph H.2., a Claimant shall be Notified in accordance with paragraph 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 paragraph 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 paragraph 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 paragraph 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 paragraph 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 paragraph 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 paragraphs 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 Group 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.

2015 Retiree Health Benefit Options

Montgomery County Government

Point-of-Service (POS) In-Area Plan brochure for Retirees and their dependents eligible for Medicare.

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Your POS In-Area Retiree Health Plan

Your Protection Against Illness and High Medical Costs

Times have changed, and so have your needs. Even though you have Medicare, you still need additional health insurance to help cover your medical expenses. That's why Montgomery County Government has selected CareFirst BlueCross BlueShield plans for you. When you use the providers who participate with Medicare, you will have little to pay for Medicare-covered services. That way, you can just concentrate on feeling better.

This benefit summary will show you how to use your benefits. As you read through it, you see terms such as deductible and approved amount. The definitions for these terms can be found in the *Words You Need to Know* section of this book. They will help you understand how your plan can save you money and make your Medicare coverage even better than before.

This benefit summary will also tell you the following:

- What the plans are and how they work.
- What Medicare does and doesn't cover.
- When you'll need to file claims, and how to file them.
- How to get the most from your health care plans.
- What your benefits are.

If you have any questions, just call CareFirst BlueCross BlueShield's Customer Service Department at 888-417-8385. You can call between 8:00 a.m. and 8:00 p.m., Monday through Friday. A customer service representative will be happy to help you.

Plan choices

- Point of Service Plan (PG52)

	Point of Service Plan* (PG52)
Medical Deductible	None
Rx Deductible	N/A
Out-of-Pocket Maximum	$1,000 Individual $2,000 Family

** These benefits are based on in-network benefits.*
This is a summary of your benefits. For complete descriptions, please see the benefits contract.

What your plan is and how it works

How do the plans work?

Your Medicare coverage is always primary. That means that Medicare always pays first for Medicare — covered services. Your CareFirst Medicare Plan is your secondary plan. It provides benefits for some charges and services not covered by Medicare.

When you use a Medicare participating provider for medical services, you will have less to pay for Medicare—covered services because these providers have agreed to accept the Medicare approved amount for their services, commonly referred to as "accepting assignment."

Medicare non-participating providers do not always accept the Medicare approved amount. You will pay more for your care when you use Medicare non-participating providers.

Sometimes Medicare non-participating providers will agree to accept the Medicare approved amount for some services. Whenever they do, you will have less to pay for covered services.

How can I save money with my plan?

Your plan pays all of your up-front Medicare Part A deductibles and coinsurance amounts, regardless if you see a Medicare participating or Medicare non-participating provider.

In addition, your plan covers the Medicare Part B deductible for most services. In these cases, you will not have to pay the deductible, even if you see a Medicare participating or Medicare non-participating provider.

Getting the most from your health care plan

To make sure that you make the most of your benefits and pay the least for care, follow these simple guidelines:

1. Always find out if a provider is participating (accepts the Medicare approved amount) or non-participating (does not accept the Medicare approved amount) before you receive care.
2. Avoid additional out-of-pocket expenses by using Medicare participating providers when you need Medicare-covered services.
3. Always give your Medicare membership number and your CareFirst membership number when you receive care.
4. If you need to file a claim, file right away so that you don't miss the filing deadline.

What Medicare Does and Doesn't Cover

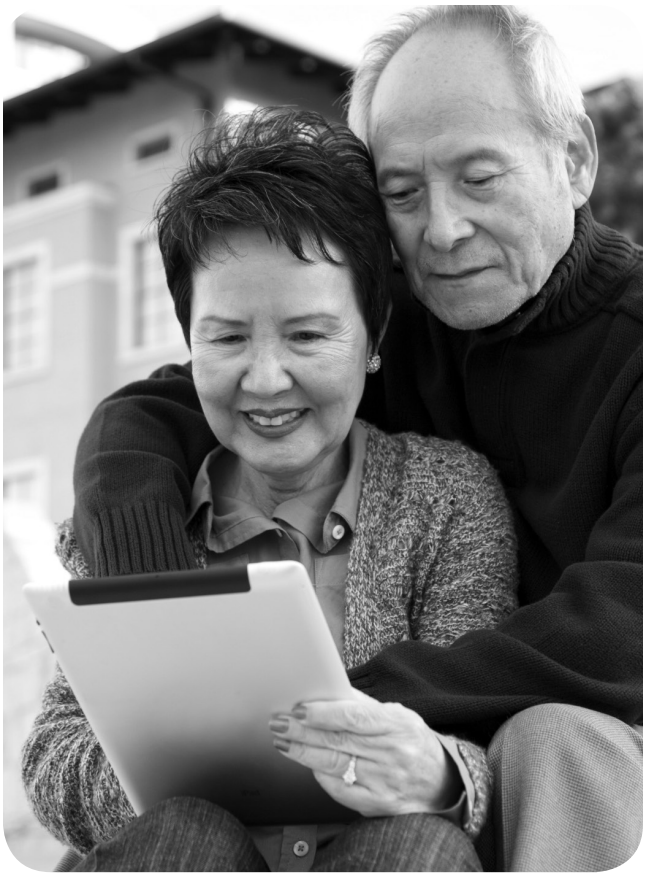
What does Medicare cover?

Medicare has two parts, A and B. Medicare Part A (hospital insurance) partially pays for medically necessary:

- Inpatient hospital facility charges.
- Care in a skilled nursing facility after a hospital stay.
- Home health care provided by a Medicare—participating home health agency.
- Hospice care for the terminally ill.

Medicare Part B (medical services insurance) partially pays for medically necessary:

- Physician's services.
- Outpatient hospital services.
- Home health visits.
- Physical and speech therapy.
- Services and supplies covered by Medicare, such as x-rays and durable medical equipment.



What isn't covered by Medicare?

Medicare does not pay the full cost of all covered services. Medicare requires that you pay a share of the costs in the form of deductibles and coinsurance/copays.

What You'll Need to File Claims

You never have to submit a claim to Medicare. By law all providers must file these claims for you. And that applies to non-participating providers as well as participating providers.

If I receive care in Maryland, will I have to file any claims to CareFirst?

You will not have to file any claims with CareFirst for covered services if you receive the services in Maryland, Washington, D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. While you may be asked to fill out claim forms for the provider, you will not have to submit the claims yourself.

CareFirst electronically receives claims from Medicare for covered services received in Maryland, Washington, D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. That means that your claims automatically come to us from Medicare when you give your CareFirst membership number to your provider at the time you receive care.

Make sure that you always give your CareFirst membership number to your provider when you give your Medicare membership number. Without your CareFirst number, Medicare won't know to forward your claim information to us. You will then have to file your own claim.

Will I have to file any claims to CareFirst if I receive care outside of the states listed above?

Yes, your providers will file your Medicare claims for you. That's the law. But you will have to file claims with CareFirst to get benefits from your plan.

Here's what you should do. After Medicare has paid its share, you will receive an "Explanation of Medicare Benefits" (EOMB). Make copies of this form and of your bills for each claim. Do not send the original EOMB and medical bills. Keep the originals in your files. Claims rarely get lost, but if that should happen, you can resubmit your claim if you have kept the originals.

Send a copy of the EOMB, your bills and a completed claim form to the following address:

- CareFirst Blue Cross Blue Shield
  Mail Administrator
  P.O. Box 14114
  Lexington, KY 40512

What if I need a claim form or help submitting a claim?

Just call your CareFirst customer service representative. The numbers to call are (410) 581-3539 or (888) 417-8385. You can also call these numbers if you want to find out if your claim has been received.

Is there a deadline for filing claims?

The Medicare timely filing period is 12 months from the date of service.

What happens if my claim arrives after the deadline?

Your claim will not be covered, and you will not receive payment. So be sure to file your claim right away.

Words You Need to Know

Approved amount

The amount that Medicare allows participating providers to be paid for Medicare-covered services. Payments are made according to the Medicare fee schedule. Participating providers agree to accept the approved amount as payment in full for covered services. Non-participating providers can charge you more than this amount for your care (see limiting charge). The "approved amount" also may be called the "allowed amount" or "assignment".

Coinsurance

Some services require that you pay a percentage of the costs for your medical care.

Some services require that you pay a set-dollar amount for your care. For example, under Medicare Part A, you must pay a set amount per day for inpatient hospital care after you've been hospitalized for over 60 days.

Your plan pays the Part A coinsurance for you.

Deductibles

Some services require that you pay a deductible before Medicare begins to pay.

Limiting charge

Some providers do not accept the Medicare approved amount as payment in full for Medicare-covered services. To protect you from high charges for these services, Medicare limits the amount that these non-participating providers can bill you. The limiting charge does not apply to any of the Traditional Medicare Supplemental Plan benefits that Medicare does not cover.

Medicare fee schedule

In general, payments for services are made according to the standard Medicare-approved fee schedule.

Medicare participating provider

Physicians and suppliers who agree to always accept the Medicare approved amount as payment in full for services. (You still pay deductibles and coinsurance.) Medicare participating providers can charge you full price for services that Medicare does not cover.

Medicare non-participating provider

Other physicians and suppliers who do not agree to always accept the Medicare Non-Participating approved amount as payment in full for services. Medicare limits the amount that non-participating providers can charge for Medicare-covered services. If you choose to see a non-participating provider, you must pay any difference between the limiting charge and the Medicare approved amount.

Provider

Any licensed doctor, nurse or professional. A provider may also be a health care facility, such as a hospital, laboratory or clinic.

Benefit Summary

Benefits	Costs	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment
FACILITY		
Inpatient Hospital Days 1–60 Days 61–90 Lifetime reserve	Part A initial deductible – $1,260 $315 per day $630 per day	$1,260 $315 per day $630 per day
Skilled Nursing Facility Days 1–20 Days 21–100	None $157.50 per day	None $157.50 per day
Home Health	None	None
Hospice Care	Medicare pays most charges. Remaining costs include drug copayment and limited cost for respite care.	Remaining cost
PHYSICIAN SERVICES		
Inpatient	20% of Medicare's approved amount and Part B deductible if accepting assignment	100% up to CareFirst allowed benefit
Emergency	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit
Surgery	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit
Laboratory Services	$0	Not applicable
Radiology Services (Inpatient)	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit
Radiology Services (Outpatient or Office)	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit
Office Visit	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit
OFFICE THERAPY		
Radiation/Chemotherapy	20% of Medicare's approved amount	100% up to CareFirst allowed benefit
Physical Therapy	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit, 100 visit maximum per calendar year, 80% benefit thereafter.

Benefits	Costs	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment
OTHER SERVICES		
Ambulance Services	20% of Medicare's approved amount and Part A/B deductible	100% up to allowed benefit
Durable Medical Equipment	20% of Medicare's approved amount and Part A/B deductible	100% up to allowed benefit
Prosthetic Appliances	20% of Medicare's approved amount deductible	100% up to allowed benefit
Whole Blood (Part A — Paid in full; Part B — 3 pint deductible)	20% of Medicare's approved amount and Part A/B deductible	100% up to allowed benefit
Medical Supplies	20% of Medicare's approved amount and Part A/B deductible	100% up to allowed benefit
Mammograms	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare

- The Medicare deductibles and coinsurance amounts shown are based on 2015 figures.
- CareFirst's allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge.
- If Medicare benefits are exhausted, or service is not covered by Medicare, CareFirst Medicare Plan benefits may be provided.
- Blue Cross and Blue Shield benefits for inpatient hospital services are provided for 90 days per inpatient stay with a 60-day renewal interval. That is, an inpatient stay will be one stay if discharge date and readmission date are not separated by at least 60 days.
- Medicare Part B deductible is $147 for 2015.

My Account

Online Access to Your Claims

View personalized information on your claims and out-of-pocket costs online with *My Account*. Simply log on to **www.carefirst.com/myaccount** for real-time information about your plan.

Features of *My Account*

- View your deductible status and out-of-pocket costs for your current and previous plan year.
- Review up to one year of medical claims—total charges, benefits paid and costs for a specific date range
- Request an ID card
- Sign up for electronic communications and get your information faster and more securely

Signing up is easy

Visit **www.carefirst.com/myaccount,** click on *Register Now* and set up your User ID and Password. You'll just need information from your member ID card.

Additional tools

Depending on your specific health plan, you may have access to the following services through *My Account:*

- Download claim forms
- Find in-netwok providers

Mobile access

View the most-visited information in *My Account* on your smartphone or tablet.

Our mobile site is available from any browser-equipped mobile device. To try out the app, visit your favorite app store, search for "CareFirst" and install the CareFirst app on your device.

Enjoy access to:

- Find a provider
- Search for nearby urgent care and ER facilities, based on your current location (as determined by your device's GPS).
- Searchable claims information
- Who's eligible and covered under your policy
- View your ID cards (App users can also print and email ID cards)
- Register for *My Account* and maintain your security and notification preferences

For more information on our mobile site and app, visit **www.carefirst.com/mobileaccess.**

health+wellness
take charge.

Whether you're looking for health and wellness tips, discounts on health-related services, or support to manage a health condition, we have the resources to help you get on the path to good health.

Health education

Find a wide variety of health education articles, nutritious recipes and cooking videos, interactive health-related tools, and more at **www.mycarefirst.com.**

Vitality magazine

Vitality provides updates to your health care plan and a variety of health and wellness topics, including food and nutrition, physical fitness, and preventive health. All issues are available online at **www.carefirst.com/vitality.**

Support during your pregnancy

Help keep yourself and your baby healthy during pregnancy. Once enrolled, Case Managers provide education and information on prenatal care and pregnancy. For more information, call (888) 264-8648.

Wellness discount program

Blue365 delivers great discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and more. Visit **www.carefirst.com/wellnessdiscounts.**

Health and wellness programs and resources help you and your family live a healthy life.

Health news

Get the latest information to help you, and your family, maintain a healthy lifestyle. To sign up for our monthly electronic member newsletter, visit **www.carefirst.com/healthnews**.

Pedometer app

Count your steps, distance traveled and calories burned for each workout with the free CareFirst Ready, Step, Go! app. The app is available for iPhone™, iPod Touch™, or Android™ smartphones—visit your app store and search for "Ready, Step, Go!"

Living with a chronic condition

Patient-Centered Medical Home (PCMH)

Living with a chronic illness can be challenging. Understanding more about your condition, and how to manage it, can help you take health challenges in stride and feel better.

PCMH was designed to provide your primary care provider with a more complete view of your health needs, as well as the care you receive from other providers. When you participate in this program, you are the focus of an entire health care team whose goal is to better manage and coordinate your care and improve your health. Talk to your doctor about PCMH to determine if it is right for you!

Dealing with the unexpected

Case Management

If you have a serious illness or injury, our Case Management program can help you navigate through the health care system and provide support along the way. Our Case Managers are registered nurses who will:

- Work closely with you and your doctors to develop a personalized treatment plan.
- Coordinate necessary services.
- Answer any of your questions.

Our Case Management program is voluntary and confidential. For more information, or to enroll, call (888) 264-8648.

Rights & Responsibilities

CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

Notice of privacy practices

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) are committed to keeping the confidential information of members private. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to send our Notice of Privacy Practices to members of fully insured groups only. The notice outlines the uses and disclosures of protected health information, the individual's rights and CareFirst's responsibility for protecting the member's health information.

To obtain a copy of our Notice of Privacy Practices, go to **www.carefirst.com** and click on *Privacy Statement* at the bottom of the page, click on *Health Information* then click on *Notice of Privacy Practices*. Or call the Member Services telephone number on your member ID card. Members of self-insured groups should contact their Human Resources department for a copy of their Notice of Privacy Practices. If you don't know whether your employer is self-insured, please contact your Human Resources department.

Member satisfaction

CareFirst wants to hear your concerns and/or complaints so that they may be resolved. We have procedures that address medical and non-medical issues. If a situation should occur for which there is any question or difficulty, here's what you can do:

- If your comment or concern is regarding the quality of service received from a CareFirst representative or related to administrative problems (e.g., enrollment, claims, bills, etc.) you should contact Member Services. If you send your comments to us in writing, please include your member ID number and provide us with as much detail as possible regarding any events. Please include your daytime telephone number so that we may contact you directly if we need additional information.
- If your concern or complaint is about the quality of care or quality of service received from a specific provider, contact Member Services. A representative will record your concerns and may request a written summary of the issues.

To write to us directly with a quality of care or service concern, you can:

- Send an email to: **quality.care.complaints@carefirst.com**
- Fax a written complaint to: (301) 470-5866
- Write to: **CareFirst BlueCross BlueShield Quality of Care Department, P.O. Box 17636 Baltimore, MD 21297**

If you send your comments to us in writing, please include your identification number and provide us with as much detail as possible regarding the event or incident. Please include your daytime telephone number so that we may contact you directly if we need additional information. Our Quality of Care Department will investigate your concerns, share those issues with the provider involved and request a response. We will then provide you with a summary of our findings. CareFirst member complaints are retained in our provider files and are reviewed when providers are considered for continuing participation with CareFirst.

These procedures are also outlined in your Evidence of Coverage.

If you wish, you may also contact the appropriate jurisdiction's regulatory department below regarding your concern:

For assistance in resolving a Billing or Payment Dispute with the Health Plan or a Health Care Provider, contact the Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General at:

Health Education and Advocacy Unit, Consumer Protection Division, Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202
Phone #: (410) 528-1840 or (877) 261-8807
Fax #: (410) 576-6571 / web site: **www.oag.state.md.us**

Hearing impaired

To contact a Member Services representative, please choose the appropriate hearing impaired assistance number below, based on the region in which your coverage originates.

Maryland Relay Program: (800) 735-2258
National Capital Area TTY: (202) 479-3546
Please have your Member Services number ready.

VIRGINIA:

Complaint Intake, Office of Licensure and Certification, Virginia Department of Health
9960 Maryland Drive, Suite 401
Richmond, VA 23233-1463
Phone #: (800) 955-1819 or (804) 367-2106
Fax #: (804) 527-4503

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Phone #: 1-877-310-6560 or (804) 371-9032

DISTRICT OF COLUMBIA:

Department of Insurance, Securities and Banking
801 1st Street, NE, Suite 701
Washington, DC 20002
Phone #: (202) 727-8000

MARYLAND:

Maryland Insurance Administration
Inquiry and Investigation, Life and Health
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone #: (800) 492-6116 or (410) 468-2244

Office of Health Care Quality, Spring Grove Center
Bland-Bryant Building, 55 Wade Avenue
Catonsville, MD 21228
Phone #: (410) 402-8016 or (877) 402-8218

Language assistance

Interpreter services are available through Member Services. When calling Member Services, inform the representative that you need language assistance.

Please Note: CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

Confidentiality of subscriber/ member information

All health plans and providers must provide information to members and patients regarding how their information is protected. You will receive a Notice of Privacy Practices from CareFirst or your health plan, and from your providers as well, when you visit their office.

CareFirst has policies and procedures in place to protect the confidentiality of member information. Your confidential information includes Protected Health Information (PHI), whether oral, written or electronic, and other nonpublic financial information. Because we are responsible for your insurance coverage, making sure your claims are paid, and that you can obtain any important services related to your health care, we are permitted to use and disclose (give out) your information for these purposes. Sometimes we are even required by law to disclose your information in certain situations. You also have certain rights to your own protected health information on your behalf.

Our responsibilities

We are required by law to maintain the privacy of your PHI, and to have appropriate procedures in place to do so. In accordance with the federal and state Privacy laws, we have the right to use and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We may disclose your protected health information to the plan sponsor/employer to perform plan administration function. The Notice is sent to all policy holders upon enrollment.

Your rights

You have the following rights regarding your own Protected Health Information. You have the right to:

- Request that we restrict the PHI we use or disclose about you for payment or health care operations.
- Request that we communicate with you regarding your information in an alternative manner or at an alternative location if you believe that a disclosure of all or part of your PHI may endanger you.
- Inspect and copy your PHI that is contained in a designated record set including your medical record.
- Request that we amend your information if you believe that your PHI is incorrect or incomplete.
- An accounting of certain disclosures of your PHI that are for some reasons other than treatment, payment, or health care operations.
- Give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice.

Inquiries and complaints

If you have a privacy-related inquiry, please contact the CareFirst Privacy Office at (800) 853-9236 or send an email to **privacy.office@carefirst.com**.

Members' rights and responsibilities statement

Members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.

- Receive information about the health plan, its services, its practitioners and providers, and members' rights and responsibilities.
- Participate with practitioners in decision-making regarding their health care.
- Participate in a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities.
- Voice complaints or appeals about the health plan or the care provided.

Members have a responsibility to:

- Provide, to the extent possible, information that the health plan and its practitioners and providers need in order to care for them.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the plans and instructions for care that they have agreed on with their practitioners.
- Pay copayments or coinsurance at the time of service.
- Be on time for appointments and to notify practitioners/providers when an appointment must be canceled.

Eligible individuals' rights statement wellness and health promotion services

Eligible individuals have a right to:

- Receive information about the organization, including wellness and health promotion services provided on behalf of the employer or plan sponsors; organization staff and staff qualifications; and any contractual relationships.

- Decline participation or disenroll from wellness and health promotion services offered by the organization.
- Be treated courteously and respectfully by the organization's staff.
- Communicate complaints to the organization and receive instructions on how to use the complaint process that includes the organization's standards of timeliness for responding to and resolving complaints and quality issues.

Habilitative services

CareFirst provides coverage for habilitative services to members younger than the age of 19. This includes habilitative services to treat congenital or genetic birth defects, including a defect existing at or from birth, a hereditary defect, autism or an autism spectrum disorder, and cerebral palsy.

Habilitative services include speech, physical and occupational therapies. CareFirst must pre-approve all habilitative services. Any deductibles, copayments and coinsurance required under your contract apply. Policy maximums and benefit limits apply. Habilitative services are not counted toward any visit maximum for therapy services.

Please note that any therapies provided through the school system are not covered by this benefit. This coverage applies only to contracts sold to businesses based in Maryland. Check your contract coverage to determine if you are eligible to receive these benefits. If you have questions regarding any of these services, contact Member Services at the telephone number on your member ID card.

Mastectomy-related services

CareFirst provides coverage for home visits to members who undergo a mastectomy (the surgical removal of all or part of the breast as a result of breast cancer) or the surgical removal of a testicle. Coverage includes one home visit that occurs within 24 hours after discharge from the hospital or outpatient facility and an additional home visit if prescribed by the member's doctor. To be eligible, the member must be in the hospital less than 48 hours or have the procedure performed on an outpatient basis. This coverage applies only to contracts sold to businesses based in Maryland. Please check your contract coverage to determine if you are eligible for these surgical procedure benefits.

CareFirst offers other benefits for mastectomy-related services, including:

- All stages of reconstruction of the breast that underwent the mastectomy.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis (artificial breast) and treatment of the physical complications that occur at all stages of the mastectomy, including lymphedema (swelling).

You and your physician will determine the appropriate plan to treat your condition. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits covered under your health plan. Please refer to your Benefit Guide or Evidence of Coverage for more details or call Member Services at the telephone number on your member ID card.

Care for mothers, newborns

Under the Newborns' and Mothers' Health Protection Act, CareFirst offers coverage for inpatient hospitalization services for a mother and newborn child for a minimum of:

- 48 hours of inpatient hospitalization care after an uncomplicated vaginal delivery.
- 96 hours of inpatient hospitalization care after an uncomplicated cesarean section.

If the mother and newborn remain in the hospital for at least the length of time provided, coverage includes:

- A home visit if prescribed by the attending physician.
- The mother may request a shorter length of stay if, after talking with her physician, she decides that less time is needed for her recovery.

If the mother and newborn have a shorter hospital stay than listed above, coverage includes one home visit scheduled to occur within 24 hours after hospital discharge and an additional home visit if prescribed by the attending physician.

CareFirst BlueCross BlueShield
CareFirst BlueChoice, Inc.
10455 Mill Run Circle
Owings Mills, MD 21117-5559

www.carefirst.com

Health benefits administered by:

CONNECT WITH US:

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

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