Montgomery County Government

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For Your Reference

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

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

You can also send written inquiries to Member Services at:

Mail Administrator
PO Box 14115
Lexington, KY 40512-4115

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

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

Introduction

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

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

Highlights of the Point-of-Service Program Option

- The Plan covers most of your healthcare needs and enables you to choose where to receive services:
  - from your PCP you selected. By doing so, you will be covered in-network, which means you will incur the least out-of-pocket expense and will not have to file a claim;
  - from a Participating Provider who contracts with CareFirst to provide services at a fixed cost (Participating Providers are not always in-network providers);
  - from any other covered provider that CareFirst recognizes as an eligible provider of medical services (Non-Participating Provider).

- The Plan has an Open Access feature, which allows you to choose a PCP to coordinate your care, but you can visit specialists such as dermatologists, podiatrists and other specialist without a referral. You can also self-refer to providers in either the Maryland Point-of-Service Network or the CareFirst BlueChoice Network. All Members must select a PCP to receive In-Network services. A Member may choose a PCP from either of the Provider Networks.

- When you go to a Participating Provider, that is out-of-network, you are covered at a percentage of the Allowed Benefit after you have met your annual deductible. Participating Providers have agreed to accept the Allowed Benefit as payment in full for covered services. You will also have no claims to file and you will not be billed for any amount over the allowed amount. You or your Participating Provider must obtain any required authorization.

- Non-Participating providers are doctors and hospitals that do not participate with CareFirst. When you go to a Non-Participating Provider you need to coordinate your own care and obtain any required authorization. You may need to pay for services up-front and then file claim forms for reimbursement. Non-Participating Providers may not accept the Allowed Benefit as payment in full for covered services. You may be responsible for paying any charges that exceed the Allowed Benefit.

- Covered services include the following if medically necessary:

  - doctor's office visits;
  - laboratory tests and X-rays;
  - preventive care;
  - inpatient and outpatient hospital services;
  - mental health and substance abuse services.

How the Point-of-Service Program Option Works

The Choice Is Yours

The following table shows the steps involved when you choose to go to an in-network provider or an out-of-network provider for medical care.

In-Network	**If you see your In-Network PCP provider** ▪ You pay a Copayment ▪ No need to file claim forms	**If you need hospitalization, home health care or hospice services** ▪ Your provider will obtain necessary approval and arrange services ▪ You file no claim forms
Out-of-Network	**If you see an Out-of-Network Participating Provider** ▪ After you meet your annual deductible, the plan pays out-of-network benefits directly to the provider ▪ You are responsible for paying a percentage of the cost of covered services	**If you see a Non-Participating Provider** ▪ You may need to pay the full amount of services immediately ▪ File a claim and, after you have met your annual deductible, receive reimbursement of Allowed Benefit for services
	If you need hospitalization, home health care or hospice services: ▪ Call the Utilization Management section of CareFirst for approval of services ▪ Pay your bills at the time of service, or authorize your provider to file a claim ▪ You may be responsible for paying any expenses not covered by the plan ▪ File claim forms	

Out-of-Pocket Costs

Your out-of-pocket costs will depend on the type of provider you or your family members see when you need care:

- In-Network
- Out-of-Network

Annual deductible

When you seek care In-Network from your PCP, you are not required to satisfy an annual deductible. For most Out-of-Network services, you must first meet an annual deductible before the program will begin to pay benefits. The following deductibles will apply:

Individual coverage	$300
Family coverage	$600

If you have family coverage, the family deductible can be met by any number of family members — however, one family member may not contribute more than the individual deductible toward the family limit. Once the family deductible is met, the deductible for all covered family members will be satisfied.

After you meet the deductible, you will also be responsible for coinsurance.

Copayment A Copayment is the portion that you pay at the time services are received. Under the High Option Program, in most cases, your Copayment for services rendered by your PCP and a specialist typically require a $10 Copayment. Under the Standard Option Program, in most cases, your Copayment for services rendered by your PCP is $15 and services rendered by a specialist is $30. For a more complete list of Copayment amounts refer to the Schedule of Benefits or call Member Services at 1-888-417-8385.

Coinsurance For out-of-network services, you are responsible for a percentage of the cost of services you receive, called coinsurance. For most services, you will pay a percentage of the Allowed Benefit (usually 20%).

Out-of-pocket maximum If you or a covered family member gets seriously hurt or sick, your medical expenses could be quite high. Once you have met your out-of-pocket maximum, the plan pays 100% of the Allowed Benefit for your covered medical expenses. The following out-of-pocket maximum will apply:

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

NOTE: The following items do not contribute toward out-of-pocket expense limits:

- charges above the Allowed Benefit for services rendered by any Non-Participating Provider
- penalties for failure to comply with the Utilization Management Program
- non-covered services
- services applied to the calendar year deductible

Filing a Claim

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

Claim forms are available by calling Member Service at 1-888-417-8385. Attach an itemized bill to your completed claim form and submit it to:

Mail Administrator
PO Box 14115
Lexington, KY 40512-4115

All In-Network claims must be filed ninety (90) days after the date the services were rendered or supplies were received. You are only responsible for filing claims for urgent or emergency care services that were provided by an Out-of-Network Provider. In this instance, you are also responsible for providing information requested by CareFirst, including medical records.

All claims being filed under the Out-of-Network portion of the Point-of-Service Plan must be submitted within fifteen (15) months after the date the services were rendered or supplies were received.

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

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

POINT-OF-SERVICE PROGRAM DESCRIPTION

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

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

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

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

SECTION 1
DEFINITIONS

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

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

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

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

BlueChoice means CareFirst BlueChoice, Inc., the administrator of the In-Network BlueChoice Program Option benefits.

BlueChoice Physician means a licensed doctor who has entered into a contract with CareFirst BlueChoice, Inc. to provide services to Members and who has been designated by BlueChoice as a BlueChoice Physician.

BlueChoice Program Option or "Program" means the coverage that is available to Members who elect to enroll in the BlueChoice Program Option through which Covered Services are available through a network of physicians and other providers. In-network Benefits under BlueChoice are made available to Members through a network arrangement operated by CareFirst BlueChoice, Inc., a subsidiary of CareFirst.

BlueChoice Provider is any physician, health care professional or health care facility that has entered into a contract with CareFirst BlueChoice, Inc. and has been designated by BlueChoice to provide services to Members under the Contract.

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

Claims Administrator means CareFirst.

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

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

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

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

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

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

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

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

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

C. The Technology must improve the net health outcome;

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

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

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

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

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

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

A. Licensed by the appropriate State authorities; or

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

C. Approved by Medicare.

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

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

Maryland Point-of-Service Program Option or "Program" means the coverage available to Eligible Members who elect to enroll in the Maryland Point-of-Service Program Option through which Members may receive Covered Services from either an In-Network provider or from an Out-of-Network Provider.

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

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

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

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

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

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

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

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

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

Membership Categories under the Contract are:

- **Individual Coverage**, which covers the Employee only;
- **Two-Party Coverage**, which covers the Employee and:
  - spouse; or
  - Domestic Partner; or
  - Dependent Child
- **Family Coverage**, which covers the Employee and two or more Dependents.

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

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

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

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

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

Service Area means the geographic area within which CareFirst BlueChoice's services are available. The Service Area is as follows: the District of Columbia; the State of Maryland; in the state of Virginia, the cities of Alexandria and Falls Church, the counties of Arlington and the portion of Fairfax east of Route 123 including the incorporated limits of Fairfax City and the town of Vienna in their entirety. CareFirst may amend the defined Service Area at any time, with notification to the Group.

Specialist is a licensed health care provider to whom a Member can be referred to by a Primary Care Physician.

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

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

SECTION 2
ELIGIBILITY AND ENROLLMENT

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

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

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

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

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

2.2 Eligibility as an Employee/Member. To be eligible as an Employee/Member, the individual must meet the basic requirements as stated below and any additional eligibility requirements to which the Group has agreed. These are set below and in the Group Application (available through your Group).

A. Basic Plan Requirements. You must be a permanent active or retired employee of the Group or of one of the participating agencies of the Group, or in a class of temporary employees eligible for benefits.

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

C. An eligible employee or eligible participant of the Group, who is subject to the provisions of the Family and Medical Leave Act of 1993, as stated therein.

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

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

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

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

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

B. Be unmarried;

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

1. A natural child;

2. A legally adopted child or grandchild;

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

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

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

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

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

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

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

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

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

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

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

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

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

4. The Member provides CareFirst with proof of the child's certified medical incapacity, within 31 days after the child's coverage would otherwise terminate or within 31 days after the Effective Date of the child's coverage under the Contract, whichever is later. CareFirst has the right to verify whether the child is and continues to qualify as an incapacitated child.

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

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

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

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

First Eligibility Date:

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

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

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

4. For a minor for whom guardianship has been granted by court or testamentary appointment, the date of the appointment.

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

Individual Coverage. If the Employee/Member is enrolled under Individual Coverage on the child's First Eligibility Date, the child will be covered automatically, but only for the first 31 days following the child's First Eligibility Date. The Employee/Member may

continue coverage beyond this 31 day period, but the Employee/Member must enroll the child within 60 days following the child's First Eligibility Date. Premium changes resulting from the addition of the child will be effective as of the child's First Eligibility Date.

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

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

First Eligibility Date:

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

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

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

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

1. Special enrollment for certain individuals who lose coverage:

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

   b. Individuals eligible for special enrollment.

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

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

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

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

2) When Dependent loses coverage.

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

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

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

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

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

c. Conditions for special enrollment.

1) Loss of eligibility for coverage. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph 1.c.1) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage. Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:

a) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;

b) In the case of coverage offered through an HMO, or other

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

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

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

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

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

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

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

that the statement be notarized.)

2. Special enrollment with respect to certain Dependent beneficiaries:

   a. Provided the Group provides coverage for Dependents, CareFirst will permit the individuals described in paragraph 2.b. of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Contract.

   b. Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph 2.b.1), 2), 3), 4), 5), or 6) of this section.

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

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

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

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

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

         a) The employee and the spouse become married; or

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

      4) Dependent of a participant only. An individual is described in this paragraph if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, Adoption, or placement for Adoption.

      5) Current employee and a new Dependent. A current employee and an individual who is a Dependent of the employee, are described in this paragraph if the individual becomes a Dependent of the employee through marriage, birth, Adoption, or placement for Adoption.

      6) Current employee, spouse or Domestic Partner, and a new Dependent. A current employee, the employee's spouse, and the employee's Dependent are described in this paragraph if the Dependent becomes a Dependent of the employee through marriage, birth, Adoption, or placement for Adoption.

First Eligibility Date:

1. Special enrollment for certain individuals who lose coverage

The employee must notify the Group, and the Group must notify CareFirst no later than 30 days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

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

2. Special enrollment for certain Dependent beneficiaries

The employee must notify the Group, and the Group must notify CareFirst during the 31-day special enrollment period beginning on the date of the marriage, birth, or Adoption or placement for Adoption

Dependents are effective as follows:

In the case of marriage: the date of marriage.

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

In the case of an adopted child: the date of Adoption, which is the earlier of the date a judicial decree of Adoption is signed; or the assumption of custody, pending Adoption, of a prospective adoptive child by a prospective Adoptive parent.

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

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

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

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

2. Notification Requirement.

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

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

under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

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

a. the date the employee's or Dependent's coverage is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or,

b. the date the employee or Dependent is determined to be eligible for premium assistance with respect to coverage under this Contract.

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

A. **Open Enrollment Effective Date**. Enrollment or changes in enrollment will be effective January 1, 2009, which is the Group's Open Enrollment Effective Date/Anniversary Date, if the requirements of Section 2.6.A are met.

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

If a Section 125 Plan, within 31 days after any event which, in the judgment of the Plan Administrator qualifies as a status change or other allowable change under Section 125 of the Internal Revenue Code (family status changes) a new Employee/Member is eligible for coverage effective on the date as determined by the Employee/Members Office of Human Resources.

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

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

If a Section 125 Plan, within 31 days after any event which, in the judgment of the Plan Administrator qualifies as a status change or other allowable change under Section 125 of the Internal Revenue Code (family status changes) a new Employee/Member is eligible for coverage effective on the date as determined by the Employee/Members Office of Human Resources.

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

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

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

1. The Subscriber's Domestic Partner.

2. The Eligible Dependents of a Domestic Partner.

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

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

B. **Definitions**

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

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

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

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

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

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

4. They are at least 18 years old;

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

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

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

8. They are legally competent to contract;

9. They share sufficient financial and legal obligations; or

10. They have legally registered the Domestic Partnership, if

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

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

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

1. The Affidavit For Domestic Partnership signed in the presence of a notary public by both the Employee/Member and the Employee/Member's Domestic Partner under

penalty of perjury declaring that they satisfy the requirements of Domestic Partnership; or

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

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

   a. Joint housing lease, mortgage, or deed;

   b. Joint ownership of a motor vehicle;

   c. Joint checking or credit account;

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3
MEDICAL CHILD SUPPORT ORDERS

3.1 Definitions

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

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

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

B. **Qualified Medical Support Order ("QMSO")** means a Medical Child Support Order issued under State law, or the laws of the District of Columbia, and when issued to an employer sponsored health plan that complies with The Child Support Performance and Incentive Act of 1998, as amended.

3.2 Eligibility and Termination

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

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

First Eligibility Date:

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

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

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

1. Was born out of wedlock.

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

3. Does not reside with the Subscriber.

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

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

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

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

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

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

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

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

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

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

C. Provide benefits directly to:

1. The non-insuring parent;

2. The provider of the covered services; or

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

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Member Coverage by CareFirst.

A. CareFirst can terminate coverage if CareFirst determines:

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

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

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

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

5. The Member failed to establish a patient-provider relationship as described in Attachment A, Section 1, Selection of Primary Care Physician.

4.2 Termination of Coverage by the Employee/Member.

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

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

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

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

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

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

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

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

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

4.3 Loss of Eligibility as a Dependent. Coverage of Dependents will automatically terminate when the Dependent reaches the Limiting Age or there is a change in the Dependent's status or relationship to the

Employee/Member such that the Dependent no longer meets the eligibility requirements of the Contract. Termination of Coverage of Dependents due to loss of eligibility will be effective as stated in Section 2, Eligibility and Enrollment.

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

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

4.4 Death of an Employee/Member. In the event of the Employee/Member's death, coverage of any Dependents will continue until, under a newly assigned identification number, as determined by the Employee/Members Office of Human Resources.

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

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

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

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

4.8 Extension of Benefits for the Point-of-Service (In-Network benefits only) Program Option. If a Member is confined in an institution in which benefits are covered under this Contract on the date this Contract terminates (unless termination is due to failure to pay a premium when otherwise eligible to do so), CareFirst will continue to provide the benefits described in this Contract, until the earliest of the following:

A. The date the confinement ceases;

B. The date the Member is no longer, in the judgment of CareFirst's Medical Director, or his or her designee, medically required to continue care as an inpatient; or

C. 90 days following termination.

4.9 Extension of Benefits for the Point-of-Service (Out-of-Network benefits only) Program Option.

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

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

2. 12 months after the date coverage terminates.

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

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

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

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

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

2. 12 months after the date coverage terminates.

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

C. This section does not apply if:

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

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

SECTION 5
MULTIPLE COVERAGE

5.1 Coordination of Benefits ("COB")

A. **Applicability**

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

2. If this COB provision applies, the Order Of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:

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

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

B. **Definitions**

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

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

CareFirst Plan means this Contract.

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

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

The term Plan does not include:

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

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

3. Coverage regulated by a motor vehicle reparation law;

4. The first $100 per day of a Hospital indemnity contract; or,

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

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

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

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

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

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

C. **Order of Determination Rules**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2) Second, the benefits under the continuation coverage.

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

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

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

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

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

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

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

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

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

2. Insurance companies, or,

3. Other organizations.

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

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

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

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

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

5.3 Medicare Eligibility. This provision applies to Members who are enrolled in Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of 65 or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in the Contract. Benefits that are covered by Medicare are subject to the provisions in this Part.

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

B. **Medicare as Primary**.

1. When benefits for Covered Services are paid by Medicare as primary, CareFirst will not duplicate those payments. When CareFirst coordinates the benefits with Medicare, CareFirst payments will be based on the Medicare allowance (if the provider is a participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare).

2. Benefits under CareFirst will be coordinated as described above to the extent a benefit would have been provided or payable under Medicare if the Member had diligently sought to establish his or her right to such benefits. Members shall agree to complete and submit to Medicare, CareFirst and/or Contracting

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

5.4 Personal Injury Protection ("PIP") Coverage.

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

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

5.5 Subrogation

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

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

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

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

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

SECTION 6
CLAIMS PROCEDURES

A. SCOPE AND PURPOSE

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

B. CLAIMS PROCEDURES

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

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

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

C. CLAIMS PROCEDURES COMPLIANCE

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

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

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

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

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

D. CLAIM FOR BENEFITS

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

E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

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

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

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

      1) Receipt of the specified information, or

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

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

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

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

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

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

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

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

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

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

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

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

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

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

   e. In the case of an Adverse Benefit Determination:

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

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

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

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

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

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

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

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

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

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

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

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

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

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

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

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

J. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

   a. Was relied upon in making the benefit determination;

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

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

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

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

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

SECTION 7
GENERAL PROVISIONS

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

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

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

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

A. Medical Claims (In-Network Point-of-Service Program Option) – ninety (90) days after the date the services were rendered or supplies were received. The Member is only responsible for filing claims for urgent or emergency care services that were provided by an Out-of-Network non-participating Provider. In this instance, the Member is also responsible for providing information requested by CareFirst, including medical records.

All claims being filed under the Out-of-Network portion of the Point-of-Service Program Option must be submitted within fifteen (15) months after the date the services were rendered or supplies were received.

A Member's failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible, and except in the absence of legal capacity of the Member, not later than one year from the time proof is otherwise required.

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

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

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

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

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

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

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

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

7.9 Member Medical Records. It may be necessary to obtain Member medical records and information from Hospitals, skilled nursing facilities, physicians or other practitioners who treat the Member. When a Member becomes covered under the Contract, the Member (and if the Member is legally incapable of giving such consent, the representative of such Member) automatically gives CareFirst permission to obtain and use such records and information, including medical records and information requested to assist CareFirst in determining benefits and eligibility of Members.

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

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

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

7.13 Rights under Federal Law. The Contract may be subject to federal law including the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") and/or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Group is the "Plan Administrator" for the purposes of ERISA and/or COBRA. As the Plan Administrator, it is the Group's responsibility to provide the Member with certain information, including access to, and copies of, plan documents describing benefits and rights to coverage under the Group health plan. Such rights include the right to continue coverage upon the occurrence of certain "qualifying events." Under HIPAA, Certificates of Creditable Coverage will be provided by CareFirst. In any event, the Member should check with the Group to determine their rights under ERISA, COBRA, and/or HIPAA, as applicable.

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

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

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

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

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

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

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

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

contracting, the representative of such Member agrees) to all the terms, conditions and provisions of the Contract.

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

7.18 Events outside of CareFirst's Control.

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

B. When an event outside the control of CareFirst affects the operations of CareFirst or BlueChoice Providers, CareFirst and BlueChoice Providers will use their best efforts to continue to provide and arrange benefits and services to Members under the Contract, taking into account the impact of the event on facilities and personnel and the extent to which the services required by the Member are Medically Necessary and urgently needed.

C. If CareFirst and BlueChoice Providers are unable to provide or arrange benefits in a reasonable manner and within a reasonable time of the Member's request, coverage will be provided for covered services obtained from any physician, Hospital or provider of the Member's choice. The Member or the provider will be reimbursed for the cost of such services up to the benefit limits of the Contract if, and to the extent, CareFirst determines:

1. That the services would have been covered under the Contract if provided or arranged by a BlueChoice Provider;

2. That obtaining these services from a BlueChoice Provider was impossible, impractical or would have entailed a medically unacceptable delay; and

3. That the services were Medically Necessary and urgently needed.

D. Except as provided in Sections B and C above, neither CareFirst nor any BlueChoice Provider will have any liability or obligation for delay or failure to provide or arrange any services or benefits when the delay or failure is caused by an event outside CareFirst's control.

7.19 Relationship to BlueChoice Physicians and Other BlueChoice Providers. BlueChoice Physicians and BlueChoice Providers are independent contractors or organizations and are related to CareFirst by contract only. BlueChoice Physicians and BlueChoice Providers are not employees or agents of CareFirst and are not authorized to act on behalf of or obligate CareFirst with regard to interpretation of the terms of the Contract, including eligibility of Members for coverage or entitlement to benefits. BlueChoice Physicians maintain a physician-patient relationship with the Member and are solely responsible for the professional services they provide. CareFirst is not responsible for any acts or omissions, including those involving malpractice or wrongful death of BlueChoice Physicians, BlueChoice Providers or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

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

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

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

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

1. Issuance of Automatic Certificates

a. Qualified Beneficiaries Upon A Qualifying Event

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

b. Other Members When Coverage Ceases

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

If a Member's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease on the earliest date that a claim is denied due to the operation of the lifetime limit.

c. Qualified Beneficiaries When COBRA Ceases

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

2. Any Individual Upon Request

CareFirst will provide a certificate in response to a request made by, or on behalf of, a Member at any time while the Member is covered under this Contract and up to 24 months after coverage ceases. CareFirst will provide the certificate by the earliest date that CareFirst, acting in a reasonable and prompt fashion, can provide the certificate. CareFirst will provide the certificate regardless of whether the Member has previously received a certificate under paragraph B.1.b., paragraph 2 or B. 1.b of this section.

C. Combining Information For Families

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

SECTION 8
CONVERSION PRIVILEGE

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

A. Notification

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

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

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

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

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

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

B. Conversion Privilege Triggers

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

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

3. **Upon Termination of Marriage**
   If a spouse's coverage terminates because of legal separation, divorce or legal annulment, the spouse is entitled to purchase a Conversion Contract.

4. **Upon Termination of Coverage of a Child**
   If coverage of a Dependent child terminates because the child no longer meets the eligibility requirements, then the child is entitled to purchase a Conversion Contract.

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

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

C. Exceptions

CareFirst will not issue a Conversion Contract if:

1. The Member is enrolled in a health maintenance organization, or is covered or eligible for coverage under another group policy which provides benefits substantially equal to the minimum benefits of the Conversion Contract.

2. The Member is eligible for Medicare;

3. Termination under the Group Contract occurred because:

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

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

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

   d. The Member failed to pay a required premium.

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

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

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

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

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

D. Application

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

ATTACHMENT A
DESCRIPTION OF COVERED SERVICES
POINT-OF-SERVICE PLAN

This Attachment A describes the medical services eligible for coverage under the Point-of-Service Program Option. The coverage to which Members are entitled is subject to the limitations stated in the Schedule of Benefits. For services covered by the Point-of-Service Program Option, the Schedule of Benefits will state the payments the Program will make, the charges for which the Member will be responsible, and any specific limits on the number of services that will be covered.

SECTION 1
GENERAL PROVISIONS

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

Deductible:	For most Covered Services, the Program does not begin to pay benefits until a Member meets his or her deductible for that year. The deductible will be calculated on a calendar year basis. Under the Program, there may be a single deductible for In-Network and Out-of-Network services or separate deductibles that apply to each. This is explained in the Schedule of Benefits. Until the deductible is satisfied, when a Member receives services subject to the deductible he or she must pay for them directly. Once a Member has satisfied the deductible, the Program will pay for Covered Services, less coinsurance, and Copayments. The Schedule of Benefits provides additional information about the deductible(s), including the amount of the deductible(s), how the deductible(s) apply to In-Network and Out-of-Network services and a listing of the services that are subject to the deductible(s). Common Accident Deductible When two or more family Members incur Covered Services due to the same accident, only one individual Deductible amount will be applied in a Benefit Period.
Coinsurance	Once the deductible is met (or for services that are not subject to the deductible), benefits are based on a sharing of costs between the Member and the Program. For most Covered Services, these costs are shared based on the percentage of the cost that the Program pays and the percentage that the Member must pay. These percentages are referred to as the coinsurance.
Copayment	A Copayment is similar to coinsurance, except that Copayments are set as a fixed dollar amount, rather than as a percentage of expenses.
Annual Out-of-Pocket Limit	This feature limits the maximum amount that a Member will have to pay in coinsurance in any given year. Under the Program, there may be a combined out-of-pocket maximum for In-Network and Out-of-Network services or separate out-of-pocket maximums that apply to each. This is explained in the Schedule of Benefits. Once a Member meets the annual Out-of-Pocket Limit, he or she will no longer be required to pay a share of the coinsurance for the remainder of that year.
Lifetime Maximum	There is a cap on the total benefits that the Program will pay on behalf of any individual Member. Reinstatement. This Group Contract has a reinstatement provision if the Lifetime Maximum has been met.

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

The **Allowed Benefit** (In-Network) payable to a Contracting Physician or Contracting Provider for a Covered Service will be the lesser of:

1. The provider's actual charge, which, in some cases, will be a rate set by a regulatory agency; or

2. The benefit amount, according to the CareFirst rate schedule for the Covered Service that applies on the date that the service is rendered.

   The benefit payment is made directly to the Contracting Provider and is accepted as payment in full, except for the copayment and coinsurance amounts stated in the Schedule of Benefits. The Member is responsible for any applicable copayment and coinsurance as stated in the Schedule of Benefits, and the Contracting Provider may bill the Member directly for such amounts.

For a non-Contracting Provider, the greater of:

1. 125% of the rate the health maintenance organization pays in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same Covered Service, to a similarly licensed provider under written contract with the health maintenance organization; or,

2. The rate as of January 1, 2000 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same Covered Service, to a similarly licensed provider not under written contract with the health maintenance organization.

For a non-Contracting Trauma Physician for Trauma Care rendered to a Trauma Patient in a Trauma Center, at the greater of:

1. 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same Covered Service, to a similarly licensed provider; or

2. The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same Covered Service, to a similarly licensed provider

   Benefits may be paid to the Subscriber or to the non-Contracting Provider at the discretion of CareFirst. The Member is responsible for the non-Contracting Physician or non-Contracting Provider's total charge and the non-Contracting Physician or non-Contracting Provider may bill the Member directly. It is the Member's responsibility to apply any CareFirst payments to the claim from the non-Contracting Physician or a non-Contracting Provider.

Allowed Benefit (Out-of-Network) means:

For a Participating Provider, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the service in effect on the date that the service is rendered. The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment and Coinsurance amounts, for which the Member is responsible.

For a Non-Participating Practitioner, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit for a Participating Provider. The benefit is payable to the Member or to the provider, at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts and for the difference between the Allowed Benefit and the Practitioner's actual charge.

For a Non-Participating Facility, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or the established Allowed Benefit if one has been established for that type of Eligible Provider and service. In some cases, and on an individual

basis, CareFirst is able to negotiate a lower rate with an Eligible Provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment and Coinsurance amounts, for which the Member is responsible. The benefit is payable to the Member or to the Facility, at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts and, unless negotiated as stated above, for the difference between the Allowed Benefit and the Practitioner's actual charge. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Participating Facility.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

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

Comprehensive Physical Rehabilitation Services means a program of coordinated, integrated, interdisciplinary, physician-directed services provided by or under the supervision of physicians qualified or experienced in Rehabilitative Services that:

1. Includes evaluation and treatment; and

2. Incorporates:

   a. Occupational Therapy, Physical Therapy, respiratory therapy, Speech Therapy;

   b. Audiology, psychology, nursing care, medical social work.

Contracting Physician means a licensed doctor who has entered into a contract with CareFirst to provide services to Members and who has been designated by CareFirst as a Contracting Physician.

Contracting Provider means any physician, health care professional or health care facility that has entered into a contract with CareFirst and has been designated by CareFirst to provide services to Members.

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoyer/stair lifts, ramps, shower/bath bench, items available without a prescription.

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

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

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

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

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

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

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

In-Network Facility means a Participating Provider which is a facility that has a written agreement with CareFirst BlueCross BlueShield to render covered services to the Member in accordance with the terms and conditions of either our National Capital Area Point-of- Service Plan or our Maryland Point-of-Service Plan. The fact that a facility in a Participating Provider does not guarantee that the facility is an In-Network Facility.

In-Network Practitioner means a Participating Provider who is a licensed Health Care Practitioner and who has a written agreement with CareFirst BlueCross BlueShield to render covered services to the Member in accordance with the terms and conditions of either our National Capital Area Point-of-Service Plan or our Maryland Point-of-Service Plan. The fact that a Health Care practitioner is a Participating Provider does not guarantee that the Health Care Practitioner is an In-Network Practitioner.

A listing of In-Network Providers will be provided to the Member when they enroll and is also available from us upon request. The listing of In-Network Providers is subject to change. The Member may confirm the status of any provider prior to making arrangements to receive care by contacting us for up-to-date information.

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, Cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.

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

A listing of Preferred Providers will be provided to Members when they enroll and is also available from CareFirst upon request. The listing of Preferred Providers is subject to change. Members may confirm the status of any provider prior to making arrangements to receive care by contacting CareFirst for up-to-information, or by accessing www.carefirst.com.

Primary Care Physician means a Contracting Physician or Contracting Provider selected by a Member to provide and manage the Member's health care.

Provider Network means those providers who have contracted with CareFirst BlueCross BlueShield ("CareFirst") to render covered services as described in the Description of Covered Services. Two Provider Networks are available through CareFirst:

A. Providers who contract with CareFirst of Maryland, Inc. (MPOS).

B. Providers who contract with CareFirst BlueChoice, Inc. (CFBC).

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

1.3 Benefits Under the Point-of-Service Plan. The Point-of-Service Plan offers two levels of benefits. The Member may select the benefit level at which coverage will be provided each time care is sought. Under the Point-of-Service Plan, the Member may receive benefits for a particular service under either the In-Network component or the Out-of-Network component. The Member may not receive duplicate benefits for the same services.

A. In-Network Benefits. In-Network benefits apply when covered services are provided by the Members Primary Care Physician or obtained from other In-Network Providers. In-Network benefits also apply to covered emergency services or urgent care, even if obtained from Out-of-Network Providers.

When In-Network benefits apply, the Member is eligible for a higher level of benefits than the Out-of-Network component. When the Member uses an In-Network Provider, benefits are based on the appropriate In-Network Provider Allowance. The level of benefits is reflected in the Schedule of Benefits. In-Network Providers will submit claims to us directly for covered services. The In-Network Provider will accept 100% of the In-Network Provider Allowance as full payment for covered services.

B. **Out-of-Network Benefits**. Out-of-Network benefits apply when the Member obtains covered services from a Provider who is not an In-Network Provider. When the Out-of-Network benefits apply, the Member will receive reduced benefits for covered services. When the Member uses a provider that is not an In-Network Provider benefits are based on the appropriate Allowed Benefit. The level of Out-of-Network benefits is shown in the Schedule of Benefits. The Member may be responsible for amounts in excess of the Allowed Benefit for these services.

1. When benefits require prior approval by CareFirst under utilization management requirements (see Section 2) it is the Member's responsibility to ensure that an approval is obtained and to ensure that services are rendered in accordance with such approval in order to qualify for benefits.

2. Members may receive benefits for a particular episode of care under either the In-Network component or the Out-of-Network component. Members or providers may not combine In-Network and Out-of-Network benefits within the same episode of care or receive duplicate benefits for the same services.

3. If a Member's admitting physician in a non-Provider Network Provider, the entire course of treatment is considered Out-of-Network, even if the Member is admitting to a Contracting Hospital.

1.4 Open Access Feature. Members are not required to obtain referrals in order to receive covered In-Network services from Contracting Providers. This provision eliminates the need for standing referrals to Network Specialists for conditions or diseases that are life threatening, degenerative, chronic, or disabling, and which require specialized medical care.

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

A. is not an Eligible Provider;

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

C. resides in the Member's home.

1.6 Selection of a Primary Care Physician.

A. A Member must select a Primary Care Physician to receive In-Network services. A Member may select any Primary Care Physician from either of the Provider Networks. Members may also self-refer o either the Maryland Point-of-Service Network (MPOS) or the CareFirst BlueChoice Network.

If a Member has selected a Primary Care Physician and receives services from:

1. Another Primary Care Physician, (with or without a referral) the Member is charged the Primary Care Physician copayment;

2. A Provider that is not a Primary Care Physician, (with a referral) the Member is charged the specialist copayment.

If a Member has not selected a Primary Care Physician and receives services from a Contracting Provider who is a Primary Care Physician:

1. If there is room on their panel and will accept the Member, the Member will be assigned to this Primary Care Physician and charged the Primary Care Physician copayment;

2. If there is no room on their panel and/or will not accept the Member as a patient benefits will be paid as Out-of-Network.

Except for that noted in Section, 11.5, Conditions for a Referral to a Non-Contracting Specialist, if a Member receives services from:

1. A Contracting Provider that is not a Primary Care Physician, (without a referral) benefits will be paid as Out-of-Network;

2. Any Non-Contracting Provider, benefits will be paid as Out-of-Network.

B. Members may change their Primary Care Physician at any time by notifying the Member Service Representative in writing. If the Member notifies CareFirst by the 20th day of the month, CareFirst will make the change effective the first day of the next month. If the Member notifies CareFirst after the 20th day of the month, CareFirst will make the change effective the first day of the second month following the notice.

C. CareFirst may require a Member to change to a different Primary Care Physician if:

1. The Member's Primary Care Physician is no longer available as a Primary Care Physician under the coverage provided by the Program; or

2. CareFirst determines that the furnishing of adequate medical care is jeopardized by a seriously impaired physician-patient relationship between the Member and Primary Care Physician, due to any of the following:

   a. The Member refuses to follow a treatment procedure recommended by the Primary Care Physician and the Primary Care Physician believes that no professionally acceptable alternative exists;

   b. The Member engages in threatening or abusive behavior toward the physician, the physician's staff, or other patients in the office; or

c. The Member attempts to take unauthorized controlled substances from the Primary Care Physician's office, or to obtain these substances through fraud, misrepresentation, forgery, or by altering the physician's prescription order.

3. If a change in Primary Care Physicians is required under Section 1.2.A, CareFirst will notify the Member in advance. If a change is required under Section 1.2.C, the action is effective upon written notice to the Member. If a Member is required to change to another Primary Care Physician due to any of the circumstances described in Section 1.2.C, and there is a recurrence of the same or a similar situation with another Primary Care Physician, CareFirst may terminate the Member's coverage upon 31 days written notice.

1.7 Out-of-Area Care.

A. Definitions

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

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

B. BlueCard Program

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

Limitations on Types of Services Processed through the BlueCard Program
BlueCard, and BlueCard PPO, if applicable, enable Members to access Host Blues networks of contracted providers for services rendered outside the Service Area.

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

The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim

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

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

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

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

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

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

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

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

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

2. To add a surcharge.

Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst would then calculate the Member and the Group/Sponsor liability for any BlueCard-eligible covered service in accordance with the applicable statute for the state or area where the Host Blue conducts business in effect at the time the Member received those services. However, when this payment methodology results in a conflict of statutes or regulations between two states, CareFirst will comply with the statutes of the jurisdiction in which the Group/Sponsor's Contract was issued.

Return of Overpayments

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

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

Utilization Management Requirements and BlueCard

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

1. Ensuring all Utilization Management Requirements are followed;

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

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

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

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

BlueCard Fees and Compensation

The Group/Sponsor understands and agrees:

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

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

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

BlueCard Eligibility Claim Types

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

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

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

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

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

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

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

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

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

   1) Ensuring all Utilization Management Requirements are followed;

   2) Any penalties for not complying with such requirements;

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

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

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

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

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

1.8 Plan Benefit Payments. Except when the Member receives services under the BlueCard Program as described above, benefit payments are based on the Allowed Benefit, as determined by CareFirst, for various types of services and providers.

A. When services are rendered to a Member by a provider who is not under written contract with CareFirst, CareFirst shall pay the provider or the Member, at the discretion of CareFirst, within 30 days after receipt of the claim.

B. When services are covered under the Out-of-Network component, providers are not required to accept the Allowed Benefit as full payment and may collect additional amounts from the Member, up to the providers' full charges. The Allowed Benefit may be substantially lower than the amount actually charged to the Member. When services are covered under the Out-of-Network component, Members will generally be required to pay additional amounts to providers that exceed the Allowed Benefit.

1.9 Filing Claims.

A **In-Network**. Under Section 9, Emergency Services and Urgent Care, of Attachment A, Description of Covered Services, Members may be required to submit claims to CareFirst in order to receive benefits for qualifying Emergency Services and Urgent Care. When a Member obtains covered urgent or emergency care services from a non-Network Provider, the Member must submit a completed claim form, or have the provider submit a completed claim form, to CareFirst no later twelve (12) months following the date of service or, if the services were provided to the Member resulted in an inpatient admission, no later than 90 days following discharge. A claim form will be provided to the Member upon request. The Member is also responsible for providing information requested by CareFirst, including, but not limited to, medical records.

Failure to file the claim within the time required does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, if the claim is filed as soon as reasonably possible and, except in the absence of legal capacity, not later than 1 year from the time proof is otherwise required.

For In-Network services provided by Network Providers, Members are not required to submit claims in order to obtain benefits. Billing and reimbursement will be handled by CareFirst directly with Network Providers.

In all other instances, all claims for Covered Services and supplies must be submitted to CareFirst within the time frames listed below:

1. If the claim for Covered Services and/or supplies is submitted by a Network Provider, within the time frame provided in the contract between CareFirst and the provider;

2. If the claim for Covered Services and/or supplies is submitted by a non-Network Provider, within the time frame granted to the Member to file a claim;

B. **Out-of-Network**.

1. **Member Responsibility to File Claims.** When services are covered under the Out-of-Network component, Members are required to submit claims or have claims filed by their provider in order to receive benefits.

3. **Time in which to File Claims**. When a Member obtains Covered Services under the Out-of-Network component, the Member must submit a completed claim form, or have the provider submit a completed claim form, to CareFirst within twelve (12) months after the date the services were rendered or supplies were received. If the services were provided to the Member as a result of an inpatient admission, no later than 180 days following discharge. A claim form will be provided to the Member upon request. The Member is also responsible for providing information requested by CareFirst, including but not limited to, medical records.

Failure to file the claim within the time required does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, if the claim is filed as soon as reasonably possible and, except in the absence of legal capacity, not later than 1 year from the time proof is otherwise required.

In all other instances, if a claim for Covered Services and/or supplies is submitted by a non-Provider Network Provider, the claim must be submitted within the time frame granted to the Member to file a claim.

SECTION 2
UTILIZATION MANAGEMENT REQUIREMENTS

IMPORTANT

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

Prior authorization is not required for services covered by Medicare.

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

2.2 Provider Responsibility. Providers are responsible for providing Utilization Management notices and obtaining necessary Utilization Management approvals on the Member's behalf for certain types of services and/or episodes of care. These are designated in the Schedule of Benefits. For these services, Members will not be responsible for notification and approvals. However, the Member must advise the Provider that he or she is eligible under the Program. In addition, Members must comply with Utilization Management Requirements and determinations. If the Member refuses to follow these requirements, coverage will be reduced or excluded. In all other instances, it is the Member's responsibility to comply with the Utilization Management Requirements described in Section 2.5.

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

2.4 Procedures. To initiate Utilization Management review, a Member may directly contact CareFirst or may arrange to have notification given by a family member or by the physician, provider, or facility that is involved in the Member's care. These individuals will be deemed to be acting on the Member's behalf. If the Member and/or the Member's representatives fail to contact CareFirst as required, or if they provide inaccurate or incomplete information, the Member will be responsible for any reduction or exclusion of benefits.

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

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

A. **Hospital Inpatient Services**. All hospitalizations (excluding maternity) require pre-certification. A Member must contact CareFirst (or have his physician or the Hospital contact CareFirst) at least five (5) business days prior to an elective or scheduled admission to the Hospital. If the admission cannot be scheduled in advance because it is not medically feasible to delay the admission for five (5) business days due to a medical condition, CareFirst must receive notification of the admission as soon as possible but, in any event, within 48 hours following the beginning of the admission, or the end of the first business day following the beginning of the admission, whichever is earlier.

B. **Inpatient Mental Health and Substance Abuse Services**. All hospitalizations for Mental Health and Substance Abuse services require pre-certification. A Member must contact CareFirst or its designee (or have his physician or the Hospital contact CareFirst or its designee) at least five (5) business days prior to an elective or scheduled admission to the Hospital. If the admission cannot be scheduled in advance because it is not medically feasible to delay the admission for five (5) business days due to a medical condition, CareFirst must receive notification of the admission as soon as possible but, in any event, within 48 hours following the beginning of the admission, or the end of the first business day following the beginning of the admission, whichever is later.

C. **Outpatient Mental Health and Substance Abuse Services**. CareFirst or its designee will review and evaluate claims for Outpatient Mental Health and Substance Abuse services to assess the medical necessity and appropriateness of the services. CareFirst will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment.

D. **Other Services**. If a Member requires any of the following services, the Member must contact CareFirst (or have the Member's physician, Hospital, or other provider facility contact CareFirst) at least five (5) business days prior to the anticipated date upon which the elective admission or treatment will commence:

1. Habilitative Services;
2. Home Health Care Services;
3. Skilled Nursing Facility Services;
4. Hospice Care Services;
5. Outpatient Private Duty Nursing;
6. Infertility Services.
   - Artificial Insemination (AI);
   - Intrauterine Insemination (IUI);
   - Assisted Reproductive Technology, including:
     * In-Vitro Fertilization (IVF);
     * Gamete Intra-fallopian Transfer (GIFT);
     * Zygote Intra-fallopian Transfer (ZIFT).

CareFirst reserves the right to make changes to the categories of services that are subject to Utilization Management Requirements or to the procedures Members and/or providers must follow. CareFirst will notify the Group or Member of such changes.

2.6 Concurrent Review and Discharge Planning. Following timely notification as described above, CareFirst will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of approved treatment.

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

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

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

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

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

E. Referral of Member to community resources.

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

SECTION 3
OUTPATIENT AND OFFICE SERVICES

3.1 Covered Outpatient Medical Services. Members are entitled to benefits for the Covered Services listed below when provided by Contracting Providers.

A. Office visits, medical care, urgent care, surgery and consultations, with a PCP and other Contracting Providers. This includes a history and baseline examination after enrollment.

B. Diagnostic Procedures.

C. Laboratory Tests and X-ray Services rendered by designated Contracting Providers, whether ordered by a Contracting Provider or a non-Contracting Provider.

D. Cancer Screening. Benefits are provided for cancer screening, including:

1. Prostate-specific antigen (PSA) tests and digital rectal exams are covered:

a) For men who are between 40 and 75 years of age;

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

c) When used for staging in determining the need for a bone scan for patients with prostate cancer; or,

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

2. Pap smears, at intervals appropriate to the Member's age and health status, as determined by CareFirst, including tests performed using FDA approved gynecological cytology screening technologies.

3. Low dose mammography screenings to determine the presence of occult breast cancer as determined to be appropriate by a CareFirst Physician and in accordance with CareFirst Preventive Guidelines.

4. Colorectal cancer screening. Benefits are available for colorectal cancer screening in accordance with the most current guidelines issued by the American Cancer Society.

E. Health Exams. Health exams and other services for the prevention and detection of disease, at intervals appropriate to age, sex and health status as determined by CareFirst. These services are not covered if required solely for:

1. Employment;

2. Insurance;

3. Travel;

4. School;

5. Camp admissions; or

6. Participation in sports activities.

F. Immunizations. Coverage is provided in accordance with accepted medical practice. Immunizations required solely for travel are not covered.

G. Allergy Testing and Treatment. Benefits include allergy testing and treatment, including administration of injections and allergy serum.

H. Obstetric and Gynecological Care. Except for infertility services, a female Member can self-refer to a Contracting Provider obstetrician-gynecologist. Benefits include health care services incidental to and rendered during an annual visit. The obstetrician-gynecologist may need to contact the Member's PCP to arrange referrals for additional services from another specialist. Consultation with the PCP may be by telephone or electronically.

A Member who is pregnant may self refer to a Contracting Provider obstetrician-gynecologist. Thereafter, the obstetrician-gynecologist may assume responsibility 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.

A female Member may receive Medically Necessary and routine obstetric and gynecological care from a Contracting Provider who is a certified nurse midwife or other health care practitioner authorized under state law to provide obstetric and gynecological services without a referral from her Primary Care Physician.

A certified nurse midwife or other health care practitioner shall consult with an obstetrician/gynecologist with whom the certified nurse midwife or other health care practitioner has a collaborative agreement, in accordance with the collaborative agreement, regarding any care rendered for the Member under this paragraph.

I. Well Child Preventive Care and pediatric services in accordance with the most recent guidelines of the American Academy of Pediatrics.

J. Eye Examinations. Eye examinations for the diagnosis and treatment of a medical condition. Annual routine eye examinations and eye refraction via self-referral to a Contracting Provider optometrist or vision center or upon referral to a Contracting Provider ophthalmologist.

K. Routine Hearing Screenings.

L. Rehabilitative Services. Coverage shall include Occupational Therapy, Physical Therapy and Speech Therapy as defined below subject to any limitations as stated in the Schedule of Benefits.

Definitions.

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

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

c. **Physical Therapy (PT)** means the short-term treatment described below

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

2. Covered Physical Therapy, Speech Therapy, or Occupational Therapy services are not subject to referral or utilization management requirements, if treatment is received from a Network Provider.

M. Radiation Therapy.

N. Chemotherapy.

O. Family Planning Services. Coverage includes but is not limited to:

1. Contraceptive counseling;

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

P. Renal Dialysis (Hemodialysis and Peritoneal dialysis for Chronic Kidney Conditions). Coverage will be provided for Medically Necessary services including equipment, training and Medical Supplies, required for home dialysis.

1. Benefits will not be provided for any furniture, plumbing, electrical or other fixtures, Convenience Items or for professional assistance needed to perform the dialysis treatment in the home.

2. If it is determined that a Member no longer meets the criteria for Medical Necessity, CareFirst's obligation is limited to paying for services up to the date that determination is communicated to the Member.

Q. Blood and Blood Products.

1. Administration of infusions and transfusions.

2. Blood and blood products (including derivatives and components) that are not replaced by or on behalf of the Member.

R. Spinal Manipulation Services.

1. 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.

2. Covered spinal manipulation services are not subject to referral or utilization management requirements, treatment is received from a Network Provider

S. Visual Therapy.

3.2 Outpatient Surgical Care. Benefits are available for the following services in a Hospital or in an ambulatory surgical facility, in connection with a covered surgical procedure. Services provided to the Member as an outpatient in a Hospital must receive prior authorization from CareFirst.

A. Use of operating room and recovery room.

B. Use of special procedure rooms.

C. Anesthesia services and supplies.

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

E. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

F. Medical and surgical supplies.

G. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administrations of infusions are covered.

H. Coverage will be available for the following surgical procedures performed by Health Care Practitioners on an outpatient basis subject to the applicable Utilization Management Requirements (Section 2).

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

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

   a. if the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the contract based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.

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

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

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

A. Benefits are limited to:

1. Infertility counseling;

2. Testing;

3. Assisted reproductive technologies as described and limited below.

B. Artificial insemination.

1. Benefits are available when:

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

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

c. The treatment is pre-authorized by CareFirst.

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

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

C. In-vitro fertilization (IVF).

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

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

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

2. Benefits are available when:

a. The treatment is pre-authorized by CareFirst;

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

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

d. The Member and the Member's spouse or Domestic Partner or in the

case of a same sex Domestic Partnership, the Member must have a history of infertility of at least 2 years' duration; or, the infertility is associated with any of the following medical conditions:

i. Endometriosis;

ii. Exposure in utero to diethylstilbestrol, commonly known as DES.

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

iv. Abnormal male factors, including oligospermia, contributing to the infertility.

3. Benefits, are limited to:

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

b. Three attempts per live birth.

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

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

D. 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.

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

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

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

B. Covered Services include the following:

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

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

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

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

5. If the Member is a recipient of a covered organ/tissue transplant, we will cover the Donor Services (as defined below) to the extent that the services are not covered under any other health insurance plan or contract. Donor Services consist of services covered under your Agreement or Contract which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure which are directly related to donating the organ or tissue.

6. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant. The cost of these drugs will not be counted towards any prescription drug benefit maximum under any Attachment to this Contract.

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

3.5 High Dose Chemotherapy/ Bone Marrow or Stem Cell Transplant. Benefits will be provided for high dose chemotherapy bone marrow or stem cell transplant treatment that is not Experimental or Investigational as determined by CareFirst.

3.6 Clinical Trials. Benefits for Patient Cost to a Member in a Clinical Trial will be provided in accordance with the terms below. Prior authorization from CareFirst is required for all services.

A. Definitions.

Cooperative Group is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes:

1. The National Cancer Institute Clinical Cooperative Group;

2. The National Cancer Institute Community Clinical Oncology Program;

3. The Aids Clinical Trials Group; and,

4. The Community Programs For Clinical Research In Aids.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH is the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary service that is incurred as a result of the treatment being provided under the Clinical Trial. Patient Cost does not include:

1. The cost of an Experimental-Investigational drug or device;

2. The cost of non-health care services that a Member may be required to receive under the Clinical Trial;

3. Costs associated with managing the research associated with the Clinical Trial; or

4. Costs that would not be covered under the Contract for non-Investigational treatments.

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

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

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

C. Coverage for Patient Cost for treatment being provided will be evaluated on a case-by-case basis. Coverage for Patient Cost will be provided only if:

1. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for treatment, prevention and early detection of cancer; or

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

3. The treatment is being provided in a Clinical Trial approved by:

   a. One of the National Institutes of Health, such as the National Cancer Institute (NCI); or

   b. An NIH Cooperative Group or an NIH Center; or

   c. The FDA in the form of an Experimental-Investigational new drug application; or

   d. The federal Department of Veterans Affairs; or,

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

4. The facility and personnel providing the treatment are capable of doing so by virtue of their:

   a. Experience;

   b. Training; and,

   c. Volume of patients treated to maintain expertise;

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

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

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

3.7 Maternity Benefits.

A. Maternity Services. Benefits are provided for all female Members including:

1. Obstetrical care, prenatal, delivery, postnatal care;

2. Coverage for a Hospital stay;

3. Coverage for care rendered by a CareFirst approved licensed birthing center;

4. Collection of adequate samples for hereditary and metabolic newborn screening and follow-up;

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

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

7. Newborn hearing screening prior to discharge.

B. Postpartum Home Visits. Home visits following delivery are covered in accordance with the most current standards published by the American College of Obstetricians and Gynecologists.

1. For a mother and newborn child who have a shorter hospital stay than that provided under Section 2.2.D, Number of Hospital Days Covered, benefits will be provided for:

   a. one home visit scheduled to occur within 24 hours after hospital discharge; and

b. an additional home visit if prescribed by the attending provider

2. For a mother and newborn child who remain in the hospital for at least the length of time provided under Section 2.2.D, Number of Hospital Days Covered, benefits will be provided for a home visit if prescribed by the attending provider

3.8 Morbid Obesity.

A. Benefits are available for the surgical treatment of Morbid Obesity. The procedures must be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity and are consistent with guidelines approved by the National Institutes of Health.

B. Morbid Obesity means a body mass index that is:

1. Greater than 40 kilograms per meter squared; or

2. Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

C. As used above, 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.

3.9 Diabetic Supplies and Services.

A. Coverage will be provided for Medically Necessary diabetes equipment; diabetes supplies; and diabetes outpatient self-management training and educational services, including medical nutritional counseling at a CareFirst approved facility.

B. The services must be Medically Necessary as determined by CareFirst for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

C. In-person, outpatient self-management training and educational services, including medical nutritional therapy, shall be provided through an in-person program provided by an appropriately licensed, registered, or certified CareFirst-approved facility or health care provider whose scope of practice includes diabetes education or management.

3.10 Dental Services.

A. Accidental Injury. Benefits include Medically Necessary, as determined by CareFirst, dental services needed as a result of an accidental bodily injury (except for accidents caused by chewing) when the Member requests treatment within 60 days of the accident.

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

1. If the Member is:

   a. Seven years of age or younger;

   b. Developmentally or otherwise severely disabled; and

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

2. Or, if the Member is:

   a. Seventeen years of age or younger;

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

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

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

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

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

   a. A fully accredited specialist in pediatric dentistry;

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

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

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

6. Benefits are not provided for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporal mandibular joint disorders.

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

3.11 Oral Surgery. Benefits include:

A. Medically Necessary procedures, as determined by CareFirst, to attain functional

capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or exostoses, or drain abscesses with cellulitis and are performed on sound natural teeth and supporting structures, lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, and jaws.

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

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

D. All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for Cosmetic purposes or for correction of the malocclusion are excluded.

E. 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.

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

A. Reconstructive Breast Surgery includes:

1. Augmentation mammoplasty;

2. Reduction mammoplasty; and

3. Mastopexy.

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

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

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

3.13 Reconstructive Surgery. Benefits for reconstructive surgery are limited to surgical procedures that are Medically Necessary, as determined by CareFirst and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma or previous therapeutic intervention.

3.14 Habilitative Services.

Occupational Therapy, Physical Therapy and Speech Therapy for the treatment of a Dependent child under the age of 19 years with a congenital or genetic birth defect that enhance the Dependent child's ability to function. This includes a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defects include, but are not limited to: autism or an autism spectrum disorder and cerebral palsy.

3.15 Chlamydia and Human Papillomavirus Screening.

A. Definitions

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

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

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

B. Covered Services

1. An annual routine Chlamydia Screening Test for:

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

   b. Male Members who have Multiple Risk Factors.

2. 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.

3.16 Osteoporosis Prevention and Treatment Services.

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

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

C. Qualified Individual means:

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

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

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

4. An individual with primary hyperparathyroidism; or

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

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

3.18 Outpatient Private Duty Nursing.

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

Conditions for Coverage:

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

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

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

3.19 Cardiac Rehabilitation.

Cardiac Rehabilitation benefits are provided to Members who have been diagnosed with significant cardiac disease, as defined by CareFirst, or, who have suffered a myocardial infarction or have undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst. Services must be provided at a CareFirst approved place of service equipped and approved to provide Cardiac Rehabilitation.

Benefits will not be provided for maintenance programs.

SECTION 4
INPATIENT HOSPITAL SERVICES

HOSPITAL ADMISSIONS MUST BE AUTHORIZED OR APPROVED BY CAREFIRST

4.1 Covered Inpatient Hospital Services. A Member will receive benefits for services listed below when admitted to a Provider Network or Non-Provider Network hospital. Coverage of inpatient hospital services is subject to certification by Utilization Management for Medical Necessity. Benefits are provided for:

A. Room and Board. Room and board in a semiprivate room (or in a private room when Medically Necessary as determined by CareFirst).

B. Physician and Medical Services. Inpatient physician and medical services provided by or under the direction of the attending Contracting Physician, including:

1. Inpatient Contracting Physician visits.

2. Consultations by Contracting Physician Specialists.

3. Intensive care services.

4. Rehabilitation Services.

5. Respiratory therapy, radiation therapy and chemotherapy services.

6. Anesthesia services and supplies.

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

8. Medically Necessary Ancillary Services rendered to the Member.

9. Surgical Care. Coverage will be available for the following surgical procedures performed by Health Care Practitioners or during a covered inpatient Hospital admission for which benefits are being provided under Section 4, subject to the applicable Utilization Management Requirements (Section 2).

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

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

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

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

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

C. Services and Supplies. Related inpatient services and supplies that are not Experimental/Investigational, as determined by CareFirst, and ordinarily furnished by the Hospital to its patients, including:

1. The use of:

a. Operating rooms;

b. Treatment rooms; and

c. Special equipment in the Hospital.

2. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

3. Medical and surgical supplies.

4. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administrations of infusions are covered.

5. Surgically implanted Prosthetic devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants and pacemakers. Available benefits under this provision do not include items such as artificial limbs or eyes, hearing aids, or other external prosthetics, which may be provided under other provisions of the evidence of coverage. See Section 10, Medical Devices and Supplies and Section 3.12, Reconstructive Breast Surgery.

6. Medical social services.

4.2 Number of Hospital Days Covered. Provided the conditions, including the requirements in Section 4.3 below are met and continue to be met, as determined by CareFirst, benefits for Inpatient Hospital Services will be provided as follows:

A. Hospitalization for Rehabilitation. Benefits are provided for an admission or transfer to CareFirst approved facility for rehabilitation. Benefits provided during any confinement will not exceed the benefit limitation, if any, stated in the Schedule of Benefits. As used in this paragraph, a confinement means a continuous period of hospitalization or two or

more admissions separated by 30 days. This limit on hospitalization applies to any portion of an admission that:

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

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

B. Inpatient Coverage Following a Mastectomy. Coverage will be provided for a minimum Hospital stay of not less than:

1. Forty-eight (48) hours following a radical or modified radical Mastectomy; and

2. Twenty-four (24) hours following a partial Mastectomy with lymph node dissection for the treatment of breast cancer.

C. Hysterectomies. Coverage will be provided for vaginal hysterectomies and abdominal hysterectomies. Coverage includes a minimum stay in the Hospital of:

1. Not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy; and

2. Not less than forty-eight (48) hours for a vaginal hysterectomy.

In consultation with the Provider Network Provider, the Member may elect to stay less than the minimum prescribed above when appropriate.

D. Childbirth. Coverage will be provided for a minimum hospital stay of not less than:

1. Forty-eight (48) hours for both the mother and newborn following a routine vaginal delivery;

2. Ninety-six (96) hours for both the mother and newborn following a routine cesarean section.

Prior authorization is not required for the minimum hospital stays listed above.

Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, coverage includes additional hospitalization for the newborn for up to four (4) days.

If the delivery occurs in the Hospital the length of stay begins at the time of the delivery. If the delivery occurs outside of the Hospital the length of stay begins upon admission to the Hospital. The Member and provider may agree to an early discharge.

E. Other Hospitalization. Hospitalization for Covered Services other than those described above, will also be provided subject to the provisions of Section 4.3, below.

4.3 Inpatient Hospital Pre-Admission Review. Coverage of inpatient hospital services is subject to the requirements for pre-admission review, concurrent review and discharge planning for all covered hospitalizations. Such review and approval shall determine:

A. The need for hospitalization;

B. The appropriateness of the approved Hospital or facility requested;

C. The approved length of confinement in accordance with CareFirst-established criteria; and

D. Additional aspects such as second surgical opinion and/or pre-admission testing requirements.

E. Failure or refusal to comply with notice requirements and other CareFirst authorization and approval procedures may result in reduction of the Members benefits or exclusion of services from coverage.

Payment for Ancillary Services may not be denied solely based on the fact that the denial of the hospitalization day was appropriate. Instead a denial of inpatient Ancillary Services must be based on the Medical Necessity of the specific Ancillary Service. In determining the Medical Necessity of an Ancillary Service performed on a denied hospitalization day, consideration must be given to the necessity of providing the Ancillary Service in the acute setting for each day in question.

4.4 Comprehensive Physical Rehabilitation.

Comprehensive Rehabilitation Facility means any person that provides or holds himself out as providing Comprehensive Physical Rehabilitation Services on an outpatient basis; or a hospital that is licensed as a special Rehabilitative Services hospital.

A. The following benefits are available for a Member with physical disabilities, such as those as a result of a spinal cord or head injury:

1. Comprehensive Physical Rehabilitation Services provided by a Comprehensive Rehabilitation Facility;

2. Medical care;

3. Diagnostic services;

4. Assistive devices to aid or complement impaired body functions when furnished by the Comprehensive Rehabilitation Facility, including but not limited to wheelchairs, walkerettes, canes, braces;

5. Supplies provided by the Comprehensive Rehabilitation Facility necessary for therapeutic purposes;

6. Prescription Drugs and medicines;

7. for a Member who is an inpatient in a Comprehensive Rehabilitation Facility, bed, board and nursing care in a semiprivate room.

B. The services provided must be billed as regular services by the Comprehensive Rehabilitation Facility and be consistent with the Member's condition.

C. The Member must experience a better rate of improvement through the Comprehensive Physical Rehabilitation Services of a Comprehensive Rehabilitation Facility than the Member would through a person or hospital which is not a Comprehensive Rehabilitation Facility.

D. Rehabilitation benefits are limited to the Member's care by the Comprehensive Rehabilitation Facility; some services may be Covered Services under other provisions of the Contract when care is not by a Comprehensive Rehabilitation Facility.

Benefits are not provided for:

1. Vocational Rehabilitative Services.

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

SECTION 5
SKILLED NURSING FACILITY SERVICES

SKILLED NURSING FACILITY SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST

5.1 Covered Skilled Nursing Facility Services. When the Member meets the conditions for coverage listed below in Section 5.2, the services listed below are available to Members in a Skilled Nursing Facility:

A. Room and board in a semiprivate room;

B. Inpatient physician and medical services provided by or under the direction of the attending Contracting Physician.

C. Services and supplies that are not Experimental or Investigational as determined by CareFirst and ordinarily furnished by the facility to inpatients for diagnosis or treatment, including:

1. Use of special equipment in the facility;

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

5.2 Conditions for Coverage. Skilled Nursing Facility care must be authorized or approved by CareFirst as meeting the following conditions for coverage:

A. **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.

B. The Member must be under the care of his or her PCP or other physician to whom the Member was duly referred.

C. The admission to the Skilled Nursing Facility must be a substitute for a Hospital admission. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.

D. The Member requires Skilled Nursing Care or skilled rehabilitation services that are required on a daily basis and can only be provided on an inpatient basis. Skilled Nursing Care means non-Custodial Care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

5.3 Custodial Care Is Not Provided. Benefits will not be provided for any day in a Skilled Nursing Facility that CareFirst determines is primarily for Custodial Care.

A. Custodial Care means care that is:

1. Not directed to the cure of an illness or recovery from an accident; and

2. Mainly for meeting the activities of daily living, e.g. bathing, eating; and

3. Not routinely provided by a trained medical professional; and

4. May be provided by person without professional medical skills or professional

medical training.

B. Services may be deemed Custodial Care even if:

A Member cannot self-administer the care;

No one in the Member's household can perform the services;

Ordered by a physician;

Necessary to maintain the Member's present condition; or

Covered by Medicare.

5.4 Number of Days of Care. Benefits will be provided up to the maximum day limit, if any stated in the Schedule of Benefits.

SECTION 6
HOME HEALTH SERVICES

HOME HEALTH SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST

6.1 Covered Home Health Services. Services must be provided within the Service Area when requested by a PCP or other physician when duly referred. Benefits are provided for:

A. Part-time or intermittent home nursing care by or under the supervision of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);

B. Rehabilitative Services;

C. Part-time or intermittent home health aid services;

D. Drugs and medications directly administered to the patient during a covered home health visit and incidental Medical Supplies directly expended in the course of a covered home health visit. Drugs, medications and medical supplies for home use (other than as described above) and purchase or rental of durable medical equipment are not covered under this Section. (See Section 10, Medical Devices and Supplies. Benefits for self-administered prescription drugs may be available through an Attachment to the Contract.);

E. Diagnostic Tests and Laboratory Services ordered by the PCP or other physician to whom the Member was referred;

F. Services of a medical social worker.

6.2 Conditions for Coverage. Benefits are provided when a Member:

A. Is under the care of the PCP or other physician to whom the Member was referred;

B. Resides within the Service Area;

C. Is confined to home due to a medical condition;

D. Would otherwise be eligible for a Hospital, or Skilled Nursing Facility admission;

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

F. The Medical Necessity of home health services must be certified by CareFirst as meeting the criteria for coverage;

G. The need for home health services must not be custodial in nature.

H. Services of a home health aide, medical social worker or registered dietician may also be provided but must be under the supervision of a licensed professional (RN or LPN) nurse.

6.3 Number of Home Health Visits.

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

surgical removal of a testicle on an outpatient basis, benefits will be provided for::

1. One home visit scheduled to occur within twenty-four (24) hours after discharge from the Hospital or outpatient health care facility; and

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

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

SECTION 7
HOSPICE CARE SERVICES

HOSPICE CARE SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST

7.1 Covered Hospice Care Services. Services are covered when provided by a Qualified Hospice Care Program. CareFirst will monitor the care for ongoing appropriateness. Benefits are provided for inpatient and outpatient care and include the following:

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

B. Medical social services for the terminally ill patient and his or her Immediate Family. Immediate Family means the patient's spouse, parents, siblings, grandparents, and children;

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

D. Non-Custodial home health visits;

E. Services, visits, medical/surgical equipment or supplies; including equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member;

F. Laboratory Tests and X-Ray Services;

G. Ambulance services, when Medically Necessary as determined by CareFirst;

H. Respite Care will be limited to 14 days per Hospice Eligibility Period. "Respite Care" means temporary care provided to the terminally ill Member to relieve the Family Caregiver from the daily care of the Member;

I. Home visits within the Service Area;

J. Family Counseling will be provided for the Immediate Family and Family Caregiver before the death of the terminally ill Member when authorized or approved by CareFirst. Family Counseling means counseling given to the Immediate Family or Family Caregiver of the terminally ill Member for the purpose of learning to care for the Member and to adjust to the death of the Member. Family Caregiver means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill Member;

K. Bereavement Services will be provided for the Immediate Family or Family Caregiver of the Member for the 6-month period following the Member's death or fifteen (15) visits, whichever occurs first. Bereavement Counseling means counseling provided to the Immediate Family or Family Caregiver of the Member after the Member's death to help the Immediate Family or Family Caregiver cope with the Member's death;

7.2 Conditions for Coverage. Hospice Care Services must meet the following conditions:

A. The Member must have a life expectancy of six (6) months or less;

B. The Member's attending PCP or other referring physician must submit a written Hospice Care Services plan of treatment to CareFirst;

C. The Member must meet the criteria of the Qualified Hospice Care Program. A Qualified 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 to:

1. Individuals who have no reasonable prospect of cure as estimated by a physician; and

2. The immediate families or family caregivers of those individuals.

D. The Medical Necessity and continued appropriateness of Hospice Care Services must be authorized or approved by CareFirst as meeting the criteria for coverage.

7.3 Hospice Eligibility Period. Is the period of time that begins on the first date hospice services are rendered and will terminate one hundred eighty (180) days later or on the death of the terminally ill Member, whichever first occurs. Any extension of the Hospice Eligibility Period must be authorized or approved by CareFirst. If CareFirst determines, based on grounds of Medical Necessity, that the benefit eligibility period should be extended, eligibility will be continued for up to thirty (30) additional days of outpatient services or fourteen (14) additional days of inpatient care.

SECTION 8
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

HOSPITALIZATION MUST BE AUTHORIZED OR APPROVED BY THE MENTAL HEALTH AND SUBSTANCE ABUSE MANAGEMENT PROGRAM

8.1 Definitions.

A. The **Mental Health Management and Substance Abuse Program** refers to utilization management, benefits administration and provider network activities administered by or on behalf of CareFirst to ensure that mental health and substance abuse services are Medically Necessary and provided in a cost-effective manner.

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

C. **Partial Hospitalization** means the provision of medically directed intensive or intermediate short-term treatment for mental illness, emotional disorders, drug abuse or alcohol abuse for a period of less than 24 hours but more than 4 hours in a day for a Member or Subscriber in a licensed or certified facility or program.

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

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

8.2 Outpatient Mental Health and Substance Abuse Services. Outpatient services must be obtained from Contracting Providers upon referral from the Mental Health and Substance Abuse Management Program. Coverage of Partial Hospitalization is subject to certification under the Mental Health Management Program of the need for treatment in a Partial Hospitalization program and the duration of such treatment.

A. Coverage of mental illness, emotional disorders, and alcohol abuse and drug abuse services includes evaluation, diagnosis and treatment of acute and non-acute conditions.

B. Medication management visits in connection with mental illness, emotional disorders, alcohol abuse or drug abuse will be covered in the same manner as medication management visits for physical illnesses and will Prior authorization is not required for Methadone Maintenance Treatment.

C. Coverage of substance abuse and related mental health conditions include detoxification and Rehabilitative Services in a CareFirst designated program.

D. Other covered medical and medical Ancillary Services will be covered for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

E. Coverage for Partial Hospitalization is subject to a maximum day limit as stated in the Schedule of Benefits.

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

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

8.3 Inpatient Mental Health and Substance Abuse Services. Covered Services include the following:

A. Services for care and treatment of mental illness, emotional disorders, alcohol abuse or drug abuse, which, in the judgment of CareFirst, are Medically Necessary and treatable through inpatient hospitalization. Inpatient care is not covered if, in CareFirst's judgment, the condition and/or the treatment to be provided does not meet the criteria established by CareFirst for admission to a Hospital. Hospitalization in a specialized facility that is not a CareFirst approved facility is not covered;

B. Diagnosis and treatment for the abuse of or addiction to alcohol and drugs, including inpatient detoxification and Rehabilitative Services in an acute care Hospital or Qualified Substance Abuse Treatment Facility. A Member must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by CareFirst;

C. Visits to the patient in the Hospital or facility by Contracting Physicians and Contracting Providers are not to exceed one visit per day for each day that inpatient mental health and/or substance abuse benefits are being provided under the preceding paragraphs. For purposes of determining the number of covered inpatient professional visits utilized and the copayments applicable to such services, a visit as used in Section 7 means an inpatient consultation or group or individual session that does not exceed one hour;

D. Other covered medical and medical Ancillary Services will be covered for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

8.4 Residential Crisis Services

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

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

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

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

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

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

SECTION 9
EMERGENCY SERVICES AND URGENT CARE

9.1 Definitions.

A. **Urgent Care** means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the Hospital emergency room. An Urgent Care facility is a free-standing facility that is not a physician's office and which provides Urgent Care.

B. **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.

C. **Trauma Center** means a primary adult resource center Level I Trauma Center, Level II Trauma Center, Level III Trauma Center, or pediatric Trauma Center that has been designated by the Institute to provide care to Trauma Patients. Trauma Center includes an out-of-state pediatric facility that has entered into an agreement with the Institute to provide care to Trauma Patients.

D. **Trauma Patient** means a Member that is evaluated or treated in a Trauma Center and is entered into the State trauma registry as a Trauma Patient.

E. **Trauma Physician** means a licensed physician who has been credentialed or designated by a Trauma Center to provide care to a Trauma Patient at a Trauma Center.

9.2 Emergency Services and Urgent Care.

A. Benefits are available to a Member for Emergency Services and Urgent Care twenty-four (24) hours per day. Benefits for Emergency Services, Urgent Care and follow-up care after emergency surgery are provided regardless of whether the services are rendered inside or outside of the Service Area.

If a Member requires care while traveling or temporarily residing outside the Service Area, the Member must follow the emergency procedures established by CareFirst. In the case of travel or temporary residence outside the Service Area, benefits will be paid or provided for expenses incurred for treatment of an illness or injury only if:

1. The need for care could not reasonably have been foreseen before departing the Service Area or sufficiently in advance so as to permit the Member to return to the Service Area for the care before it became urgent;

2. The care was urgently required to alleviate acute pain or prevent further significant deterioration of the Member's condition;

3. The Member could not, without medically harmful results, return to the Service Area to receive treatment;

4. CareFirst determines that the travel was for some purpose other than the receipt of medical treatment; and,

5. CareFirst determines that the services were Medically Necessary.

B. In the case of a Hospital that has an emergency department, benefits include:

1. Appropriate medical screening;

2. Assessment and stabilization services; and

3. Ancillary Services routinely available to the emergency department, to determine whether or not an Emergency condition exists.

C. A provider is not required to obtain prior authorization or approval from CareFirst in order to obtain reimbursement for Emergency Services, Urgent Care or follow-up care after emergency surgery.

D. A Hospital, or other provider, or CareFirst, when CareFirst has reimbursed the provider, may attempt to collect payment from a Member for health care services that do not meet the criteria for Emergency Services. Benefits for these services may be covered as Out-of-Network.

E. Except as provided below, benefits are not provided for routine follow-up treatment within the Service Area provided by non- Contracting Providers. Follow-up treatment outside of the Service Area is covered if required in connection with a covered out-of-area Emergency or Urgent Care and CareFirst determines that the Member could not reasonably be expected to return to the Service Area for such care. Benefits for these services may be covered as Out-of-Network.

9.3 Notice to CareFirst in the event of an Emergency.

A. If the Member is admitted to a Hospital as a result of an Emergency, CareFirst must be notified the earlier of:

1. The end of the first business day after first receiving the care; or

2. Within 48 hours after first receiving the care.

B. If it was not reasonably possible to give notice, this requirement will be met if notice was given as soon as reasonably possible. The Member must provide information about the Emergency and the care received. If the Member does not return to the Service Area and transfer care to a Contracting Physician or Contracting Provider as soon as, in the judgment of CareFirst, the Member was able to do so without medically harmful results, no further benefits will be provided for services received on or after such date. Benefits for these services may be covered as Out-of-Network.

9.4 Ambulance Services.

A. Benefits are available for Medically Necessary air transportation and ground ambulance services as authorized and approved by CareFirst.

B. If a Member is outside of the United States and requires treatment for Emergency Services, benefits are provided for Medically Necessary air and ground transportation to the nearest facility where appropriate medical care is available.

9.5 Follow-up Care after Emergency Surgery. If CareFirst authorizes, directs, refers, or otherwise allows a Member to access a Hospital emergency facility or other urgent care facility for a medical condition that meets the criteria for Medical Emergency, as defined in the Contract, and requires emergency surgery:

A. Coverage shall be provided for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's PCP; and

B. The Member will be responsible for the same copayment for each follow-up visit as would be required for a visit to a Contracting Physician for specialty care.

SECTION 10
MEDICAL DEVICES AND SUPPLIES

MEDICAL DEVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST

10.1 Covered Benefits. Benefits will be provided for Medical Devices and Supplies when:

A. Obtained from a designated Contracting Provider; and

B. The Member has coverage under the Contract at the time that the Durable Medical Equipment, Prosthetic, Orthotic Device, or Medical Supply is prescribed and received. The Member must continue to be eligible for coverage for the duration of time for which Durable Medical Equipment is rented.

10.2 Authorization or Approval of Medical Devices and Supplies by CareFirst. Benefits are limited to the least expensive Medically Necessary Durable Medical Equipment, Medical Supply, Orthotic Device or Prosthetic adequate to meet the patient's medical needs.

To qualify for coverage for Medical Devices, the Member or the provider must contact CareFirst prior to the purchase or rental of any Medical Device to obtain prior authorization-of such purchase or rental. CareFirst will determine the Medical Necessity for the covered Medical Device and the appropriateness of the type of appliance, device, equipment or supply requested. CareFirst will then recommend the Provider Network Provider from whom the Member is authorized to obtain the Medical Device in order to receive benefits. Failure to contact CareFirst in advance of the purchase or rental and/or failure and refusal to comply with the authorization given by CareFirst will result in exclusion of the Medical Device from coverage.

10.3 Responsibility of CareFirst. CareFirst ill not be liable for any claim, injury, demand or judgment based on tort or other grounds (including express or implied warranty of equipment) arising out of or in connection with the rental, sale, use, maintenance or repair of a Medical Device.

10.4 Definitions.

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

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

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

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

4. Is consistent with the diagnosis;

5. Is appropriate for use in the home;

6. Is reusable; and can withstand repeated use.

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

C. **Inherited Metabolic Disease** means a disease caused by an inherited abnormality of body chemistry, including a disease for which the State screens newborn babies.

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

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

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

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

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

F. **Medical Food** means a food that is:

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

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

G. **Medical Supply** means items that:

Are primarily and customarily used to serve a medical purpose;

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

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

Are consistent with the diagnosis;

1. Are appropriate for use in the home;

2. Cannot withstand repeated use;

3. Are usually disposable in nature.

H. **Orthotic Device** means items that:

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

2. Are prescribed by a Health Care Provider;

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

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

5. Include devices necessary for post-operative healing.

I. **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.

10.5 Covered Services.

A. **Durable Medical Equipment**

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

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

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

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

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

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

2. Administered under the direction of a physician.

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

D. **Medical Supplies**

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

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

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

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

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

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

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

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

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

B. 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.

C. 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.

10.7 Exclusions. Specific exclusions related to Medical Devices and Supplies are listed with the Exclusions and Limitations at the end of this Description of Covered Services.

SECTION 11
EXCLUSIONS AND LIMITATIONS

11.1 Conditions for a Referral to a Non-Contracting Specialist.

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

A referral to a Specialist who is not a Contracting Physician or Provider Network Provider shall be provided if:

1. The Member is diagnosed with a condition or disease that requires specialized medical care;

2. There is no Contracting Physician or Provider Network Provider with the professional training and expertise to treat the condition or disease; and

3. The non-contracting Specialist agrees to accept the same reimbursement as would be provided to a specialist who is a Contracting Physician or Provider Network Provider.

A decision by CareFirst not to provide access to or coverage of treatment by a Specialist in accordance with this section constitutes an Adverse Benefit Determination as defined in the Program Description, if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

11.2 Continuing Care with Terminated Providers.

A. When a Provider Network Provider terminates their agreement with CareFirst, for any reason except for cause, benefits will be provided for continuing care rendered by the terminated provider as described in this Section. CareFirst will send a notice to the Member that the Contracting Provider is no longer available.

B. The Member may, upon request, continue to receive Covered Services from his/her PCP for up to 90 days after the date of the notice of the PCP's termination from CareFirst's provider panel, if termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status. In addition, a Member may continue treatment with a terminated provider if:

   1. A Member was in an active course of treatment with the terminated Provider Network Provider prior to the date the Member was notified. The Member needs to request, from CareFirst, to continue receiving care from the terminated Provider Network Provider. Benefits will be provided for a period of 90 days from the date the Member is notified by CareFirst that the terminated Provider Network Provider is no longer available.

   2. A Member who has entered her second trimester of pregnancy may continue to receive Covered Services from the terminated Provider Network Provider through postpartum care directly related to the delivery.

   3. A Member that was terminally ill (as defined by § 1861(dd)(3)(A) of the Social Security Act) at the time the Provider Network Provider's agreement terminated may continue to receive Covered Services directly related to the treatment of the terminal illness until the Member dies.

11.3 CareFirst Personnel Availability for Prior Authorization.

CareFirst requires prior authorization for certain medical treatment as stated in the Contract. Check the specific description of the Covered Services for a notice regarding prior authorization. CareFirst shall have personnel available to provide prior authorization at all times when such prior authorization is required.

11.4 Coverage Is Not Provided For:

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

B. Services that are Experimental or 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.

This exclusion will not be used, however, to deny Patient Cost when a clinical trial meets the criteria stated in Section 3.

C. The cost of services that:

1. Are furnished without charge; or

2. Are normally furnished without charge to persons without health insurance coverage; or

3. Would have been furnished without charge if a Member was not covered under the Contract or under any health insurance.

D. Services that are not described as covered in the Contract or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Referral by a PCP and/or the provision of services by a Provider Network Provider does not, by itself, entitle a Member to benefits if the services are non-covered or do not otherwise meet the conditions and criteria for coverage.

E. 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.

F. Except for treatment for Accidental Injury or benefits for Oral Surgery as described, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies.

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

H. 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.

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

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

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

L. 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.

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

N. 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.

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

P. 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.

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

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

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

T. Inpatient private duty nursing.

U. 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 charged by a Health Care Provider to a Member to retain the Health Care Provider services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Contract are limited to Covered Services rendered to a Member by a Health Care Provider.

V. Educational therapies intended to improve academic performance.

W. Vocational rehabilitation and employment counseling.

X. Routine eye examinations and frames and lenses or contact lenses. Benefits for routine eye examinations and frames and lenses or contract lenses may be available through a rider or endorsement purchased by the Group and attached to the Contract.

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

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

AA. Oral surgery, dentistry or dental process unless otherwise stated.

BB. Treatment of temporomandibular joint disorders unless otherwise stated.

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

DD. Rehabilitative Services delivered through early intervention and school services.

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

FF. 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.

11.5 Infertility Services.

Infertility Services. Coverage will not be provided for:

1. Any costs associated with freezing, storage, and thawing of the female Member's eggs and/or male Member's or donor sperm for future attempts.

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

3. Any charges associated with donor eggs.

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

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

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

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

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

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

11.6 Organ and Tissue Transplants. Coverage is not provided for:

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

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

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

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

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

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

11.7 Inpatient Hospital Services. Coverage is not provided for:

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

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

C. Except for covered Emergency Services and Maternity Care, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private duty nursing.

11.8 Home Health Care Services. Coverage is not provided for:

A. Private duty nursing.

B. Custodial Care.

C. Services in the Member's home if it is outside the Service Area.

11.9 Hospice Benefits. **Coverage is not provided for**:

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

B. Services in the Member's home if it is outside the Service Area.

C. Financial and legal counseling.

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

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

F. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.

G. Reimbursement for volunteer services.

H. Custodial Care, domestic or housekeeping services.

I. Meals on Wheels or similar food service arrangements.

J. Rental or purchase of renal dialysis equipment and supplies.

K. Private duty nursing.

11.10 Outpatient Mental Health and Substance Abuse. **Coverage is not provided for**:

A. Psychological testing, unless Medically Necessary, as determined by CareFirst and appropriate within the scope of Covered Services.

B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director.

C. Mental retardation, after diagnosis.

D. Psychoanalysis.

11.11 Inpatient Mental Health and Substance. **Coverage is not provided for**:

A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.

B. Custodial Care.

C. Observation or isolation.

11.12 Emergency Services and Urgent Care. **Coverage is not provided for**:

A. Emergency care, if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).

B. Medical services rendered outside of the Service Area that could have been foreseen by the Member prior to departing the Service Area.

C. Charges for Emergency and Urgent Care services received from a non-Contracting Provider after the Member could reasonably be expected to travel to the nearest Contracting Provider.

D. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the Emergency or Urgent Care facility outside of the Service

Area unless CareFirst determines that the Member could not reasonably be expected to return to the Service Area for such care.

E. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.

F. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency as defined in Section 8.

Benefits may be paid as Out-of-Network.

11.13 Medical Devices and Supplies. **Coverage is not provided for**:

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

B. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoyer/stair lifts, ramps, shower/bath bench.

C. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.

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

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

F. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

G. Eyeglasses, contact lenses, dental prostheses or appliances, or Hearing Aids (except as otherwise provided herein for minor children). Benefits for eyeglasses and contact lenses may be available through an Attachment to or included as a separate Section within the Contract.

H. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.

ATTACHMENT A1

SCHEDULE OF BENEFITS

HIGH OPTION

<table>
<tr><th colspan="2">HIGH OPTION GENERAL PLAN BENEFIT FEATURES</th></tr>
<tr><th colspan="2">DEDUCTIBLES</th></tr>
<tr><th>In-Network Deductible</th><th>Out-Of-Network Deductible</th></tr>
<tr><td>There is no In-Network Deductible.</td><td>The Individual Deductible is $300 per Benefit Period
The Family Deductible is $600 per Benefit Period
The following amounts apply to the Out-of-Network Deductible:
• 100% of the Allowed Benefit for covered Out-of-Network services that are subject to the Deductible, as stated in the Benefits Chart below.</td></tr>
<tr><td colspan="2">Out-Of-Network Deductible
If you have Individual Coverage, you must meet the Individual Deductible.
If you have Two-Party Coverage, each Member must satisfy his own Deductible by meeting the Individual Deductible.
If you have Family Coverage, you can satisfy your Deductible by meeting the Individual Deductible. In addition, eligible expenses of all covered family members can be combined to satisfy the Family Deductible. An individual family member cannot contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible is met in this manner, this will satisfy the Deductible for all covered family members.
The following amounts may <u>not</u> be used to satisfy the Out-of-Network Deductible:
• Copayments for Covered Services;
• Amounts incurred for failure to comply with the Utilization Management Requirements;
• The portion of any provider charge that is in excess of the Allowed Benefit.
The Benefits Chart, below, states whether a covered service is subject to a Deductible.</td></tr>
</table>

OUT-OF-POCKET LIMITS
In-Network and Out-of-Network
The Individual Out-of-Pocket Limit is $1,000 per Benefit Period for both In-Network and Out-of-Network Services.
In-Network and Out-of-Network
These amounts apply to the Out-of-Pocket Limit except as noted below: • Coinsurance for Covered Services When you have reached the Out-of-Pocket Limit, no further Coinsurance or Deductibles will be required in that calendar year for covered services. Your Out-of-Pocket Limit applies on a calendar year basis even though you may have been enrolled for less than a calendar year. The following amounts may not be used to meet the In-Network or Out-of-Network Out-of-Pocket Limits: • Amounts incurred for failure to comply with the Utilization Management Requirements; • The portion of any provider charges which is in excess of the Allowed Benefit; • The Deductible and Copayments; • Charges for services which are not covered under this Contract or which exceed the maximum number of covered visits/days under your coverage.
LIFETIME MAXIMUM
There is no Lifetime Maximum.
UTILIZATION MANAGEMENT NON-COMPLIANCE
Failure or refusal to comply with Utilization Management Requirements for Out-of-Network Services will result in: Benefits for all services associated with your care or treatment will be reduced by 20%.

BENEFITS

IN-NETWORK BENEFITS

Each family member must select a PCP from our current list of In-Network Physicians. You may elect to participate in either the CareFirst BlueChoice Point-of-Service network or the Maryland Point-of- Service network. Your choice of PCP determines which network you are participating in. If you chose to see a provider outside your chosen network (other than a specialist to which you have been referred, your benefits will be available at the out-of-network level.

When a Copayment is required for In-Network services, as noted below, you will pay the same Copayment amount whether you see your PCP or a Specialist.

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
OUTPATIENT AND OFFICE SERVICES				
Child Wellness (Including related lab tests and immunizations)	Up to age 18	100% of the Allowed Benefit, minus a Member Copayment of $10 per office visit	NO	80% of the Allowed Benefit
Adult Preventive Physical Examinations (Including related services and immunizations)	Age 18 and older Limited to 1 per calendar year	100% of the Allowed Benefit, minus a Member Copayment of $10 per office visit	YES	80% of the Allowed Benefit
Screening Mammography	Age 35-39: One baseline mammogram of each breast. Age 40 - 49: One preventive mammogram of each breast every two calendar years or more frequently if recommended by a physician. Age 50 and above: One preventive mammogram of each breast per calendar year.	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Routine Pap Tests Including Related Office Visits	Limited to 1 per calendar year	100% of the Allowed Benefit, minus a Member copayment of $10 per office visit	NO	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Prostate Cancer Services	NONE	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Osteoporosis Prevention and Treatment Services	NONE	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Office Visits	NONE	100% of the Allowed Benefit, minus a Member Copayment of $10 per office visit	YES	80% of the Allowed Benefit
Allergy Testing and Shots (including Serum)	NONE	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Maternity and Related Services	Benefits are available for the Subscriber and covered Dependents	100% of Allowed Benefit minus a Member Copayment of $10 per office visit; for maternity care, no copayment after first visit per pregnancy Sterilizations and reversals of sterilizations are not subject to the $10 copayment	YES	80% of the Allowed Benefit
In Vitro Fertilization	Limited to 3 attempts per live birth not to exceed a lifetime benefit of $100,000	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Surgical Care	Benefits apply on an inpatient or an outpatient basis	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Inpatient Medical Care	Covered only if hospitalization qualifies for coverage	100% of Allowed Benefit	YES	80% of the Allowed Benefit
Anesthesia Service (related to Acupuncture when used as a general anesthetic) (including covered general anesthesia for dental care)	Benefits apply on an inpatient or outpatient basis when provided in connection with a covered procedure General anesthesia for dental care must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Rehabilitation Therapy (speech, occupational, and physical)	Limited to 90 visits per calendar year per diagnosis for In-Network services (separate visits for each type of therapy) Out-of-Network Services not limited Note: There are no limits to Rehabilitation Therapy provided for Cleft Lip, Cleft Palate, or Both	100% of Allowed Benefit	YES	80% of the Allowed Benefit
Spinal Manipulation Services	Benefits for chiropractic/spinal manipulation services are limited to Members who are twelve (12) years of age or older	100% of Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
Outpatient Private Duty Nursing	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Acupuncture Therapy	Covered for pain management where traditional methods were tried and failed	100% of the Allowed Benefit minus a Member Copayment of $10 per office visit	YES	80% of the Allowed Benefit
Visual Therapy		100% of the Allowed Benefit minus a Member Copayment of $10 per office visit	YES	80% of the Allowed Benefit
Ambulance Service				
To or From Hospital	NONE	100% of the Allowed Benefit	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)
Foreign Transportation	Applies only if Member is traveling outside the U.S.	100% of the Allowed Benefit	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
HOSPITAL SERVICES				
Inpatient Hospital Services	Must be authorized in advance under Utilization Management Requirements Your In-Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Comprehensive Physical Rehabilitation Services		100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Inpatient and Outpatient Hospital Services performed by Radiologist, Anesthesiologist, Pathologist and Surgical Assistants		100% of the Allowed Benefit	NO	Covered at the In-Network level (for services provided by Non-Participating Providers)
Outpatient Hospital Services				
Emergency Room Treatment Initial care received within 72 hours after onset	NONE	100% of the Allowed Benefit, minus a Member Copayment of $25 per visit Waived if admitted to the hospital	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)
Cardiac Rehabilitation	Limited to 90 days per calendar year	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Comprehensive Physical Rehabilitation Services		100% of the Allowed Benefit	NO	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Organ Transplant	Limited to 365 days beginning 5 days before the day on which the Transplant is performed. Benefit Maximum of $1,000,000 for each type of covered transplant. Donor Organ Procurement limited to $50,000 per transplant Recipient Transportation and Lodging limited to: $150 per day, and $10,000 per Organ Transplant	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
SKILLED NURSING FACILITY SERVICES	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf In-Network and Out-of-Network Services (Combined) limited to 100 days per calendar year	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
HOME HEALTH CARE	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf Limited to 90 visits (up to four hours per visit) per calendar year for In and Out-of-Network Services	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
HOSPICE CARE SERVICES	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf Bereavement Counseling is limited to the 6 month period following the Member's death or 15 visits, whichever occurs first In-Network Services not limited Respite Care is limited to 14 days per Benefit Period Note: Benefits for Bereavement Counseling extend beyond the Hospice Eligibility Period	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
Outpatient Services				
Medication Management Office Visits	NONE	100% of the Allowed Benefit minus a Member Copayment of $10	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
MENTAL HEALTH AND SUBSTANCE ABUSE CARE (continued)				
Office or Outpatient Facility	Visit maximums are combined In and Out-of-Network	Per calendar year: Visits 1-5: 100% of the Allowed Benefit Visits in excess of 5: 70% of Allowed Benefit	YES	Per calendar year: Visits 1-5: 80% of the Allowed Benefit Visits 6-30: 65% of the Allowed Benefit Visits in excess of 30: 50% of the Allowed Benefit
Neuropsychological Testing		80% of the Allowed Benefit	YES	80% of the Allowed Benefit
Methadone Maintenance Treatment		100% of Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount	NO	100% of Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount
Partial Hospitalization	Must be authorized in advance under Utilization Management Requirements Limited to 60 days per calendar year Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
Hospital Inpatient	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Psychiatric Halfway House	Must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
MEDICAL DEVICES AND SUPPLIES	Must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Hair Prosthesis	Benefits are limited to one hair prosthesis per calendar year	100% of the Allowed Benefit up to $350 for one hair prosthesis	NO	100% of the Allowed Benefit up to $350 for one hair prosthesis
Hearing Aids for Minor Children	Benefits are limited to one Hearing Aid for each hearing-impaired ear once every 36 months	100% of the Allowed Benefit up to $1400 for each ear	NO	100% of the Allowed Benefit up to $1400 for each ear

ATTACHMENT A2

SCHEDULE OF BENEFITS

STANDARD OPTION

<table>
<tr><th colspan="2">STANDARD OPTION GENERAL PLAN BENEFIT FEATURES</th></tr>
<tr><td colspan="2">DEDUCTIBLES</td></tr>
<tr><td>In-Network Deductible
There is no In-Network Deductible.</td><td>Out-Of-Network Deductible
The Individual Deductible is $300 per Benefit Period
The Family Deductible is $600 per Benefit Period
The following amounts apply to the Out-of-Network Deductible:
• 100% of the Allowed Benefit for covered Out-of-Network services that are subject to the Deductible, as stated in the Benefits Chart below.</td></tr>
<tr><td colspan="2">Out-Of-Network Deductible
If you have Individual Coverage, you must meet the Individual Deductible.
If you have Two-Party Coverage, each Member must satisfy his own Deductible by meeting the Individual Deductible.
If you have Family Coverage, you can satisfy your Deductible by meeting the Individual Deductible. In addition, eligible expenses of all covered family members can be combined to satisfy the Family Deductible. An individual family member cannot contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible is met in this manner, this will satisfy the Deductible for all covered family members.
The following amounts may <u>not</u> be used to satisfy the Out-of-Network Deductible:
• Copayments for Covered Services;
• Amounts incurred for failure to comply with the Utilization Management Requirements;
• The portion of any provider charge that is in excess of the Allowed Benefit.
The Benefits Chart, below, states whether a covered service is subject to a Deductible.</td></tr>
</table>

OUT-OF-POCKET LIMITS
In-Network and Out-of-Network
The Individual Out-of-Pocket Limit is $1,000 per calendar year for both In-Network and Out-of Network Services.
In-Network and Out-of-Network
These amounts apply to the Out-of-Pocket Limit except as noted below: • Coinsurance for Covered Services When you have reached the Out-of-Pocket Limit, no further Coinsurance or Deductibles will be required in that calendar year for covered services. Your Out-of-Pocket Limit applies on a calendar year basis even though you may have been enrolled for less than a calendar year. The following amounts may not be used to meet the In-Network or Out-of-Network Out-of-Pocket Limits: • Amounts incurred for failure to comply with the Utilization Management Requirements; • The portion of any provider charges which is in excess of the Allowed Benefit; • The Deductible and Copayments; • Charges for services which are not covered under this Contract or which exceed the maximum number of covered visits/days under your coverage.
Maximum Combined Out-Of-Pocket Limit
If you are using a combination of In-Network and Out-of-Network services, this feature avoids having to meet two separate Out-of-Pocket Limits. Your total Out-of-Pocket expenses (In-Network and/or Out-of-Network combined) are limited to your Out-of-Network Out-of-Pocket Limit amount. You can meet the Maximum Combined Out-of-Pocket Limit through any combination of In-Network and/or Out-of-Network Out-of-Pocket Limit expenses. If you meet your Maximum Combined Out-of-Pocket Limit, this automatically satisfies your In-Network and Out-of-Network Out-of-Pocket Limits for that year. When you have reached the Maximum Combined Out-of-Pocket Limit, no further Coinsurance or Copayments will be required in that calendar year.
LIFETIME MAXIMUM
There is no Lifetime Maximum.
UTILIZATION MANAGEMENT NON-COMPLIANCE
Failure or refusal to comply with Utilization Management Requirements for Out-of-Network Services will result in: Benefits for all services associated with your care or treatment will be reduced by 20%.

BENEFITS				
IN-NETWORK BENEFITS Each family member must select a PCP from our current list of In-Network Physicians. You may elect to participate in either the CareFirst BlueChoice Point-of-Service network or the Maryland Point-of- Service network. Your choice of PCP determines which network you are participating in. If you chose to see a provider outside your chosen network (other than a specialist to which you have been referred, your benefits will be available at the out-of-network level. When a Copayment is required for In-Network services, as noted below, you will pay the following Copayments. PCP Copayment - $15 Specialist Copayment - $30				
SERVICE	**SPECIAL LIMITATIONS**	**PLAN COVERS**		
		IN-NETWORK	**OUT OF NETWORK DEDUCTIBLE?**	**OUT-OF NETWORK**
OUTPATIENT AND OFFICE SERVICES				
Child Wellness (Including related lab tests and immunizations)	Up to age 18	100% of the Allowed Benefit, minus a Member Copayment of $15 per office visit Specialist Copayment of $30 per office visit	NO	80% of the Allowed Benefit
Adult Preventive Physical Examinations (Including related services and immunizations)	Age 18 and over Limited to 1 per calendar year	100% of the Allowed Benefit, minus a Member Copayment of $15 per office visit Specialist Copayment of $30 per office visit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
OUTPATIENT AND OFFICE SERVICES (continued)				
Screening Mammography	Age 35-39: One baseline mammogram of each breast. Age 40 – 49: One preventive mammogram of each breast every two calendar years or more frequently if recommended by a physician. Age 50 and above: One preventive mammogram of each breast per calendar year.	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Routine Pap Tests Including Related Office Visits	Limited to 1 per calendar year	100% of the Allowed Benefit, minus a Member Copayment of $15 per office visit. Specialist Copayment of $30 per office visit	NO	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Prostate Cancer Services	NONE	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Osteoporosis Prevention and Treatment Services	NONE	100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Office Visits	NONE	100% of the Allowed Benefit, minus a Member Copayment of $15 per office visit Specialist Copayment of $30 per office visit	YES	80% of the Allowed Benefit
Allergy Testing and Shots (including Serum)	NONE	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Maternity and Related Services	Benefits are available for the Subscriber and covered Dependents	100% of Allowed Benefit minus a Member Copayment of $30 for first office visit; for maternity care No additional copayments after first visit per pregnancy Sterilizations and reversals of sterilizations are not subject to the $30 copayment	YES	80% of the Allowed Benefit
In Vitro Fertilization	Limited to 3 attempts per live birth not to exceed a lifetime benefit of $100,000	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Surgical Care	Benefits apply on an inpatient or an outpatient basis	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF-NETWORK
Inpatient Medical Care	Covered only if hospitalization qualifies for coverage	100% of Allowed Benefit	YES	80% of the Allowed Benefit
Anesthesia Service (including Acupuncture when used as a general anesthetic) (including covered general anesthesia for dental care)	Benefits apply on an inpatient or outpatient basis when provided in connection with a covered procedure General anesthesia for dental care must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Rehabilitation Therapy (speech, occupational, and physical)	Limited to 90 visits per calendar year per diagnosis for In-Network services (separate visits for each type of therapy) Out-of-Network Services not limited Note: There are no limits to Rehabilitation Therapy provided for Cleft Lip, Cleft Palate, or Both	100% of Allowed Benefit	YES	80% of the Allowed Benefit
Spinal Manipulation Services	Benefits for chiropractic/spinal manipulation services are limited to Members who are twelve (12) years of age or older	100% of Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
Outpatient Private Duty Nursing	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Acupuncture Therapy	Covered for pain management where traditional methods were tried and failed	100% of the Allowed Benefit minus a Member Copayment of $30 per office visit	YES	80% of the Allowed Benefit
Visual Therapy		100% of the Allowed Benefit minus a Member Copayment of $30 per office visit	YES	80% of the Allowed Benefit
Ambulance Service				
To or From Hospital	NONE	100% of the Allowed Benefit	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)
Foreign Transportation	Applies only if Member is traveling outside the U.S.	100% of the Allowed Benefit	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
HOSPITAL SERVICES				
Inpatient Hospital Services	Must be authorized in advance under Utilization Management Requirements Your In-Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit minus the $150 Member copay	YES	80% of the Allowed Benefit
Comprehensive Physical Rehabilitation Services		100% of the Allowed Benefit minus the $150 Member copay	NO	80% of the Allowed Benefit
Inpatient and Outpatient Hospital Services performed by Radiologist, Anesthesiologist, Pathologist and Surgical Assistants		100% of the Allowed Benefit	No	Covered at the In-Network level (for services provided by Non-Participating Providers)
Outpatient Hospital Services				
Emergency Room Treatment Initial care received within 72 hours after onset	NONE	100% of the Allowed Benefit, minus a Member Copayment of $35 per visit. Waived if admitted to the hospital	NO	Covered at the In-Network level (for a bona-fide Medical Emergency)
Emergency Treatment Outpatient Office Visit	Care must be for a bona-fide Medical Emergency	100% of the Allowed Benefit, minus a Member Copayment of $15 per visit Specialist Copayment of $30 per visit	NO	Covered as an In-Network benefit for a bona-fide emergency
Cardiac Rehabilitation	Limited to 90 days per calendar year	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
Comprehensive Physical Rehabilitation Services		100% of the Allowed Benefit	NO	80% of the Allowed Benefit
Organ Transplant	Limited to 365 days beginning 5 days before the day on which the Transplant is performed. Benefit Maximum of $1,000,000 for each type of covered transplant. Donor Organ Procurement limited to $50,000 per transplant Recipient Transportation and Lodging limited to: $150 per day, and $10,000 per Organ Transplant	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
SKILLED NURSING FACILITY SERVICES	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf In-Network and Out-of-Network Services (Combined) limited to 100 days per calendar year	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
HOME HEALTH CARE	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf Limited to 90 visits (up to four hours per visit) per calendar year for In and Out-of-Network Services	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
HOSPICE CARE SERVICES	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf Bereavement Counseling is limited to the 6 month period following the Member's death or 15 visits, whichever occurs first In-Network Services not limited Respite Care is limited to 14 days per Benefit Period Note: Benefits for Bereavement Counseling extend beyond the Hospice Eligibility Period	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
Outpatient Services				
Medication Management Office Visits	NONE	100% of the Allowed Benefit minus a Member Copayment of $15 Specialist Copayment of $30 per office visit	YES	80% of the Allowed Benefit
Office or Outpatient Facility	Visit maximums are combined In and Out-of-Network	Per calendar year: Visits 1-5: 100% of the Allowed Benefit Visits in excess of 5: 70% of Allowed Benefit	YES	Per calendar year: Visits 1-5: 80% of the Allowed Benefit Visits 6-30: 65% of the Allowed Benefit Visits in excess of 30: 50% of the Allowed Benefit
Neuropsychological Testing		80% of the Allowed Benefit	YES	80% of the Allowed Benefit
Methadone Maintenance Treatment		100% of Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount	NO	100% of Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
Partial Hospitalization	Must be authorized in advance under Utilization Management Requirements Limited to 60 days per calendar year Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Hospital Inpatient	Must be authorized in advance under Utilization Management Requirements Your Network Provider will handle In-Network Utilization Management Requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Psychiatric Halfway House	Must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	OUT OF NETWORK DEDUCTIBLE?	OUT-OF NETWORK
MEDICAL DEVICES AND SUPPLIES	Must be authorized in advance under Utilization Management Requirements	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Hair Prosthesis	Benefits are limited to one hair prosthesis per calendar year	100% of the Allowed Benefit up to $350 for one hair prosthesis	NO	100% of the Allowed Benefit up to $350 for one hair prosthesis
Hearing Aids for Minor Children	Benefits are limited to one Hearing Aid for each hearing-impaired ear once every 36 months	100% of the Allowed Benefit up to $1400 for each ear	NO	100% of the Allowed Benefit up to $1400 for each ear