EVIDENCE OF COVERAGE

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

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

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

Group Name: HOOD COLLEGE

Group Number: 0P67

Effective Date: July 1, 2010
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Amendments/Riders
SECTION 1
DEFINITIONS

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

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

Allowed Benefit means:

For a Preferred Provider, the Allowed Benefit for a Covered Service is the amount agreed upon between CareFirst and the Preferred Provider which, in some cases, will be a rate set by a regulatory agency. The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment, and Coinsurance amounts, for which the Member is responsible.

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, except for facilities that are paid in accordance with Diagnosis Related Groups (“DRG’s”). The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment, and Coinsurance amounts, for which the Member is responsible.

For a Non-Participating Practitioner, the Allowed Benefit for a Covered Service is 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. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Participating Health Care Practitioner.

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 fee schedule if one has been established for that type of Eligible Provider and service, except for facilities that are paid in accordance with Diagnosis Related Groups (“DRG's”). If a fee schedule for the type of Eligible Provider and service has not been established, the Allowed Benefit will be based on facility reimbursement methodology. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an Eligible Provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment, and Coinsurance amounts, for which the Member is responsible. The benefit is payable to the Member or to the facility, at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts and, unless negotiated, for the difference between the Allowed Benefit and the Facility'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 is a calendar year.

Cardiac Rehabilitation means inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process, and enhance the psychosocial and vocational status of eligible Members.
CareFirst means Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Serious dysfunction of any of the individual's bodily organs; or,
D. In the case of a pregnant woman, serious jeopardy to the health of the fetus. Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as CareFirst determines.

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

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

A. The Technology* must have final approval from the appropriate government regulatory bodies;
B. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
C. The Technology must improve the net health outcome;
D. The Technology must be as beneficial as any established alternatives; and,
E. The improvement must be attainable outside the Investigational settings.

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

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

FDA means the federal Food and Drug Administration.

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

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

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

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

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

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

**Infertility** means the inability to conceive after one (1) year of unprotected vaginal intercourse.

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

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

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

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

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

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

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

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

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

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

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

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

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

Payment for inpatient Ancillary Services may not be denied solely based on the fact that the denial of the hospitalization day was appropriate. A denial of inpatient Ancillary Services must be based on the Medical Necessity of the specific Ancillary Service. In determining the Medical Necessity of an
Ancillary Service performed on a denied hospitalization day, consideration must be given to the necessity of providing the Ancillary Service in the acute setting for each day in question.

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

**Non-Participating or Non-Par Provider** means any Health Care Provider that does not contract with CareFirst.

**Nonphysician Specialist** means a Health Care Provider who is not a physician; is licensed or certified under the Maryland Health Occupations Article; and is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.

**Non-Preferred Provider** means any Health Care Provider that does not contract with CareFirst or is a Participating Provider.

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

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

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

**Over-the-Counter** means any item or supply, as determined by CareFirst, that is available for purchase without a prescription, 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 or Par Provider** means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members.

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

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

**Preferred Provider** means a Health Care Provider who is part of a network of Participating Providers who contract with CareFirst to render Covered Services. Preferred Provider relates only to method of payment, and does not imply that any Health Care Provider is more or less qualified than another. The fact that a Health Care Provider is a Participating Provider does not guarantee that the Health Care Provider is a Preferred Provider.

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

**Prescription Drug** means a drug, biological, or compounded prescription intended for outpatient use that carries the FDA legend “may not be dispensed without a prescription;” and, drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.

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

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

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

**Service Area** means the clearly defined geographic area in which CareFirst has arranged for the provision of health care service to be generally available and readily accessible to Members except for emergency and urgent care services. CareFirst may amend the defined Service Area at any time by notifying the Group in writing.

The Service Area is as follows: the District of Columbia; the state of Maryland; and the following Virginia counties and cities - Arlington, Alexandria, Fairfax, City of Fairfax, Falls Church, Prince William, Manassas, Manassas Park, Loudoun and Leesburg as well as those areas contiguous to the stated Service Area in which CareFirst has contracted with providers to render services to Members.

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

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

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

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

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

**Spouse** means a person of the opposite sex who is married to a Subscriber by a ceremony recognized by the law of the state or jurisdiction in which the Subscriber resides.

**Subscriber** means a Member who is covered under this Evidence of Coverage as an eligible employee or eligible participant of the Group, rather than as a Dependent.
Type of Coverage means either Individual, which covers the Subscriber only, or Family, under which an Individual may also enroll his or her Dependents. In addition, some Group Contracts list other categories of coverage, including, but not limited to, Individual and Adult, Individual and Child, or Individual and Children. The Type(s) of Coverage available is described in the Eligibility Schedule.

Waiting Period means the period of time that must pass before an employee or Dependent is eligible to enroll under the terms of the Evidence of Coverage.
SECTION 2
ELIGIBILITY AND ENROLLMENT

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

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

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

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

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

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

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

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

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

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

2.4 Eligibility of Dependent Children. If the Group has elected to include coverage for Dependent Children of the Subscriber or a Subscriber's covered Spouse under this Evidence of Coverage, then a Subscriber may enroll a Dependent Child. A Dependent Child means an individual who:

A. Is:

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

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

3. A child under testamentary or court appointed guardianship, other than temporary guardianship for less than 12 months' duration, of the Subscriber or the Subscriber's covered Spouse;
B. Has not provided over one-half of his or her own support for the previous calendar year;

C. Is unmarried; and

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

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

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

2.5 Limiting Age for Dependent Children.

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

B. A covered Dependent Child will be eligible for coverage past the Limiting Age if at the time coverage would otherwise terminate:

1. The Dependent Child is incapable of supporting himself or herself because of mental or physical incapacity;

2. The incapacity occurred before the Dependent Child reached the Limiting Age;

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

4. The Subscriber provides CareFirst with proof of the Dependent Child's medical or mental incapacity within thirty-one (31) days after the Dependent Child's coverage would otherwise terminate. CareFirst has the right to verify whether the child is and continues to qualify as an incapacitated Dependent Child.

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

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

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

B. Newly Eligible Subscriber. If a Subscriber is a new employee or a newly eligible employee of the Group, new employee or a newly eligible employee may enroll as a Subscriber within sixty (60) days after new employee or a newly eligible employee first becomes eligible. The eligibility requirements for Newly Eligible Subscribers in the Group are stated in the Eligibility Schedule.
C. **Coverage of a Newborn Dependent Child, Newly Adopted Dependent Child, Newly Eligible Dependent Child, a Minor Dependent Child for whom Guardianship is granted by Court or Testamentary Appointment.** Enrollment requirements for an eligible newborn Dependent Child, newly adopted Dependent Child, newly eligible Dependent Child or a minor Dependent Child for whom guardianship is granted by court or testamentary appointment depend on the Type of Coverage that is in effect on the date of the Dependent Child's First Eligibility Date, as defined below.

D. "First Eligibility Date" means:

1. For a newborn Dependent Child, the child's date of birth;
2. For a newly adopted Dependent Child, the earlier of:
   a. A judicial decree of Adoption; or
   b. Placement of the Dependent Child in the Subscriber's home as the legally recognized proposed adoptive parent.
3. Newly eligible Dependent Child, the date the Dependent Child became a dependent of Subscriber or Dependent Spouse.
4. For a minor Dependent Child for whom guardianship has been granted by court or testamentary appointment the date of the appointment.

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

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

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

H. Upon receipt of a MCSO/QMSO, when coverage of the Subscriber's family members is available under the Evidence of Coverage, then CareFirst will accept enrollment of the child subject to a MCSO/QMSO submitted by the Subscriber regardless of enrollment.
period restrictions. If the Subscriber does not attempt to enroll the child subject to a MCSO/QMSO then CareFirst will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any State or the District of Columbia. If the Subscriber has not completed an applicable Waiting Period for coverage, the child subject to a MCSO/QMSO will not be enrolled until the end of the Waiting Period.

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

1. Enrollment for such a child will not be denied because the child:
   a. Was born out of wedlock.
   b. Is not claimed as a dependent on the Subscriber's federal tax return.
   c. Does not reside with the Subscriber.
   d. Is receiving benefits or is eligible to receive benefits under any Medical Assistance or Medicaid program.

2. When a 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 Evidence of Coverage or Member contract and any information necessary to obtain benefits;
   b. Allow the non-insuring custodial parent or a provider of a covered service to submit a claim without the prior approval of the Subscriber; and
   c. Provide benefits directly to the non-insuring custodial parent, the provider of the covered services, or the appropriate child support enforcement agency of any State or the District of Columbia.

I. New Family Member (Other than Newborn Dependent Child or Grandchild, Newly Adopted Dependent Child or Grandchild, Newly Eligible Dependent Child or Grandchild, a Minor Dependent Child for whom Guardianship Has Been Granted by Court or Testamentary Appointment, or Child Subject to a MCSO/QMSO). A Subscriber may enroll new family members, such as a new Spouse, and/or change the Subscriber's Type of Coverage to include the new family member within thirty-one (31) days following the date the new family member first becomes eligible.

2.7 Special Enrollment Periods. A Subscriber may enroll himself or herself and/or his or her Dependents as described below.

A. When a Subscriber was first eligible or, at the time of initial enrollment, the Subscriber did not enroll himself or herself and/or his or her Dependents because the Subscriber or the Subscriber's Dependents already had coverage under an employer sponsored plan or group health benefits plan and that coverage terminates due to any of the following:
   1. Termination of the other plan's entire group coverage;
   2. The Subscriber's divorce or legal separation;
3. Death of the Subscriber's Spouse;
4. Voluntary or involuntary termination of the Spouse's employment;
5. Involuntary loss of the Spouse's eligibility for continued group coverage;
6. Cancellation of all group health benefits programs offered by the Spouse's employer;
7. COBRA continuation coverage has been exhausted;
8. Loss of eligibility for coverage, including a reduction of hours of employment;
9. Employer contribution terminated;
10. When an individual in the individual market, no longer resides, lives or works in the HMO service area and the HMO does not provide coverage for that reason;
11. When an individual in the group market, no longer resides, lives or works in the HMO service area and no other benefit package is available to the individual;
12. When a plan no longer offers any benefits to a class of similarly situated individuals;
13. When a plan terminates a benefit package option;
14. When an insurer providing an option ceases to operate in the group market, terminating one option offered by the Plan, unless the Plan otherwise provided a current right to enroll in alternative health coverage;
15. When an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or
16. When an employee who already is enrolled in a benefit package may enroll in another benefit package if his or her Dependent has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage.

B. To qualify for coverage under this provision, the Subscriber and each family member that the Subscriber seeks to enroll must have been covered on the last day that the Subscriber or his or her Spouse's employer sponsored plan or group health benefits plan coverage was in effect. Additionally, the Subscriber must make this request, in writing, within 31 days after termination of coverage under an employer sponsored plan or group health benefits plan. Except, when a claim is denied due to an individual meeting or exceeding a lifetime limit on all benefits, the individual must be allowed thirty-one (31) days after the claim is denied. However, if the Subscriber is enrolling because his or her Spouse was involuntarily terminated from employment (other than for cause) or because of the death of his or her Spouse, the Subscriber has up to six (6) months after the termination of the Spouse's coverage to submit an Enrollment Application. CareFirst may require the Subscriber to submit proof of eligibility, including proof of prior coverage and of the circumstances under which such coverage terminated.

C. The Subscriber is eligible for coverage under this contract but is not enrolled, and an individual becomes his or her Dependent through marriage. If the Subscriber enrolls within 31 days, the Effective Date of coverage will be the first of the month following the date the completed request was received by the Plan.
D. The Subscriber is eligible for coverage under this contract, but is not enrolled, and an individual becomes his or her Dependent Child. If the Subscriber enrolls within thirty-one (31) days, the Effective Date of coverage is the date of birth, the date of Adoption or placement for Adoption, whichever occurs first, the date the Dependent Child first became a dependent of the Subscriber, the date of guardianship, or the date the date specified in the MCSO/QMSO.

E. 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.)

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

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

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

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

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

2.12 Cooperation and Submission of Information. CareFirst may require verification from the Group and/or Subscriber pertaining to the eligibility of a Subscriber or Dependent enrolled hereunder. The Group and/or Subscriber agree to cooperate with and assist CareFirst, including providing CareFirst with reasonable access to Group records upon request.
SECTION 3
TERMINATION OF COVERAGE

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

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

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

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

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

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

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

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

E. Except in the case of a Dependent child enrolled pursuant to a Medical Child Support Order or Qualified Medical Support Order, the Dependent's coverage will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract.

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

G. The Subscriber is responsible for notifying CareFirst (through the Group) of any changes in the status of Dependents that affect their eligibility for coverage. These changes include a divorce, the marriage of a Dependent child, or termination of a Student Dependent's status as a full-time student. If the Subscriber does not notify CareFirst of these types of changes and it is later determined that a Dependent was not eligible for coverage, CareFirst has the right to recover these amounts from the Subscriber or from the Dependent, at CareFirst's option.

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

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

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

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

3.3 Medical Child Support Orders or Qualified Medical Support Orders.
Unless coverage is terminated for non-payment of the premium, a child subject to a MCSO/QMSO may not be terminated unless written evidence is provided to CareFirst that:

A. The MCSO/QMSO is no longer in effect;
B. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage;
C. The Group has eliminated family member coverage for all Members; or,
D. The Group no longer employs the Subscriber, except if the Subscriber elects continuation coverage under applicable state or federal law the child will continue in this post-employment coverage.

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

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

If a Member leaves their job to perform military service, the Member has the right to elect to continue their Group coverage including any Dependents for up to twenty-four (24) months while in the military. Even if continuation of coverage was not elected during the Member's military service, the Member has the right to be reinstated in their Group coverage when reemployed, without any Waiting Periods or Preexisting Condition Exclusion Period except for service-connected illnesses or injuries. If a Member has any questions regarding USERRA, the Member should contact the plan administrator. The plan administrator determines eligible employees and provides that information to CareFirst.

C. Maryland Continuation of Coverage.
When Maryland Continuation applies, the Member may continue coverage under the Evidence of Coverage as follows:

1. Continuation for Spouse and Children after the Subscriber's Death.
This provision applies in the event of the death of a Subscriber who was a resident of Maryland, was covered under the Group Contract or predecessor Group Contract with the same employer for at least three (3) months and whose coverage included one (1) or more Dependents at the time of death. This provision also applies to a newborn child of the deceased Subscriber born to the surviving Spouse after the Subscriber's death. When this provision applies, Dependents of the Subscriber may elect to remain covered under the Group Contract until the earliest of any of the following:

a. Eighteen (18) months after the date of the Subscriber's death;

b. The date on which the Dependent fails to make timely payment for this continuation coverage;

c. The date on which the Dependent is enrolled in other Group or non-Group coverage;

d. The date on which the Dependent becomes entitled to benefits under Medicare;

e. The date on which the Dependent elects to terminate coverage under the Group Contract;

f. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's death had not occurred, for example if the child marries or attains the Limiting Age; or

g. The date on which the Group ceases to provide benefits to its employees under the Group Contract.

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

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

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

i. The date on which the Subscriber's coverage under the Group Contract is terminated;

ii. The date on which the Subscriber or Dependent fails to make timely payment for this continuation coverage;

iii. The date on which the Dependent is enrolled in other Group or non-Group coverage;
iv. The date on which the Dependent becomes entitled to benefits under Medicare;

v. With regard to the coverage of a Spouse, the last day of the month in which the Spouse remarries;

vi. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's divorce had not occurred, for example if the child marries or attains the Limiting Age;

vii. The effective date of an election by the Dependent to no longer be covered under the Group Contract; or

viii. The date on which the Group ceases to provide benefits to its employees under the Group Contract.

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

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

ii. Thirty (30) days following the Effective Date of the Subscriber's coverage under this Evidence of Coverage if, on the date of the divorce, the Subscriber was covered under a Group health plan offered through a different employer.

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

3. State Continuation for Subscriber and Dependents in the Event of Voluntary or Involuntary Termination of Employment for Any Reason Other Than Cause.

This provision applies to the voluntary and involuntary termination of employment of a Subscriber who is a resident of Maryland, who was terminated from employment for any reason other than cause and who was covered under the Group Contract or predecessor Group Contract with the same employer for at least three (3) months prior to the termination of employment.

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

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

ii. The date on which the Subscriber or Dependent fails to make timely payment for this continuation coverage;

iii. The date on which the Subscriber or Dependent is enrolled in other Group or non-Group coverage;

iv. The date on which the Subscriber becomes entitled to benefits under Medicare;
v. The effective date of an election by the Subscriber to no longer be covered under the Group Contract;

vi. The date on which the employer ceases to provide benefits to its employees under a Group Contract;

vii. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's employment had not terminated, for example if the child marries or attains the Limiting Age.

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

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

3.6 Extension of Benefits for Totally Disabled Individuals.
This section applies to hospital, medical or surgical benefits. During an extension period required under this section a premium may not be charged. Benefits will cease as of 12:01 a.m., Eastern Standard Time, on the Subscriber's termination date unless:

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

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

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

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

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

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; or,

3. Any coverage provided by a succeeding health benefit plan is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit required under this section; and does not result in an interruption of benefits.
3.7 **Right to Continue Coverage.**
If a Member is eligible to continue coverage under the Group Contract according to state and federal continuation provisions, the Member is entitled to utilize both provisions. Any differences in qualifications or benefits between the federal and state provisions will be resolved in favor of the Member.

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

3.9 **Reinstatement.**
Coverage will not reinstate automatically under any circumstances.
SECTION 4
CONVERSION PRIVILEGE

4.1 Conversion Privilege.
A. Group Conversion.
   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.

B. 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, but no 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 Evidence of Coverage terminates,
      unless one of the exceptions in 4.1C applies.
   6. Benefits under a Conversion Contract may vary from the benefits under this
      Evidence of Coverage and CareFirst reserves all rights, subject to applicable
      requirements of law, to determine the form and terms of the Conversion Contract
      CareFirst issues.

C. 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 the his/her covered Dependents.
   2. Upon Subscriber's Death.
      A Spouse, whose coverage terminates at the death of the Subscriber, may purchase
      a Conversion Contract. A Dependent child, whose coverage terminates at the
      death 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.
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.

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.

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

D. Exceptions. CareFirst will not issue a Conversion Contract to the Member 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 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.

E. Where coverage would result in overinsurance according to CareFirst standards on file with 
the Maryland Insurance Administration, CareFirst will not issue a Conversion Contract if:

1. 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.

2. The Member is covered for similar benefits under any arrangement of coverage for 
   individuals in a Group on an insured or uninsured basis or in the military.
3. Similar benefits are provided for or available to the Member, pursuant to or in accordance with the requirements of any state or federal law.

4.2 **Application.**
CareFirst must receive the Member's application form, including full payment of the applicable premium, in accordance with the provisions described in B.2 and B.3 of this section.
SECTION 5
COORDINATION OF BENEFITS ("COB"); SUBROGATION

5.1 Coordination of Benefits ("COB").
A. Applicability.

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

2. If this COB provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:
   a. Shall not be reduced when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan; but
   b. May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is described in the Effect on the Benefits section of this CareFirst Plan Evidence of Coverage.

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

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

CareFirst Plan means this Evidence of Coverage.

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

Plan means any health insurance policy, including those of nonprofit health service Plan and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage 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 one-hundred dollars ($100) per day of a Hospital indemnity contract; or,
5. An elementary and or secondary school insurance program sponsored by a school or school system.

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

1. When this CareFirst Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
2. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
3. When there are more than two Plans covering the Member, this CareFirst Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

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

C. Order of Determination Rules.

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

a. The other Plan has rules coordinating benefits with those of this CareFirst Plan; and
b. Both those rules and this CareFirst Plan's rules require that this CareFirst Plan's benefits be determined before those of the other Plan.

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

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

i. Secondary to the Plan covering the person as a dependent, and

ii. 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:

i. 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.

ii. 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.

The rule described in C.2.b.i 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.

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

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

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

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

ii. Second, the benefits under the continuation coverage.

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

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

D. Effect on the Benefits of this CareFirst Plan.

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

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

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

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

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

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

2. Insurance companies, or,

3. Other organizations.

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

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

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

B. Medicare as Primary.

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

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

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

A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

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

5.4 **Subrogation.**

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

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

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

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

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

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

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

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

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

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

G. These provisions do not apply to residents of the Commonwealth of Virginia.
SECTION 6
GENERAL PROVISIONS

6.1 Claims and Payment of Claims.

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

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

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

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

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

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

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

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

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

When a child Dependent is covered under a court or administrative order or a Qualified Medical Support Order and the parent who is not the Subscriber incurs covered expenses on the child Dependent's behalf, CareFirst reserves the right to make payment for these covered expenses to the non-Subscriber parent, the provider or the Maryland Department of Health and Mental Hygiene. In any case, CareFirst's payment will be in full and complete satisfaction of CareFirst's obligation.
6.2 **Legal Actions.**
A Member cannot bring any lawsuit against CareFirst to recover under this Evidence of Coverage before the expiration of sixty (60) days after written proof of loss has been furnished, and not after three (3) years from the date that written proof of loss is required to be submitted to CareFirst.

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

6.4 **No Assignment.**
A Member cannot assign any benefits or payments due under this Evidence of Coverage to any person, corporation or other organization, except as specifically provided by this Evidence of Coverage or required by law.

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

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

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

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

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

6.7 **Member Medical Records.**
It may be necessary to review and/or obtain medical records and information from hospitals, skilled nursing facilities, physicians or other practitioners who treat the Member. When a Member becomes covered under this Evidence of Coverage, the Member (or, if the Member is legally incapable of giving such consent, the representative of such Member) automatically gives CareFirst permission to obtain and use such records and information, including without limitation medical records and information requested to assist CareFirst in determining benefits and eligibility of Members.

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

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

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

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

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

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

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

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

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

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

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

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

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

6.15 Notices.
Whenever the terms of the Group Contract or Evidence of Coverage require the Member, CareFirst or the Group to "give notice" or "notify" another party, the following requirements apply:
A. To the Subscriber.
Notices to Subscribers will be sent by mail to the most recent address for the Subscriber in CareFirst's files. The notice will be effective on the date mailed, whether or not the Subscriber in fact receives the notice or there is a delay in receiving the notice.

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

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

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

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

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

B. Individuals for Whom Certificate Must be Provided; Timing of Issuance.
1. Issuance of Automatic Certificates.
   a. Qualified Beneficiaries Upon A Qualifying Event.
      In the case of an individual entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the individual would lose coverage in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. CareFirst will provide the certificate no later than the time a notice is required to be furnished for a qualifying event relating to notices required under COBRA.
   b. Other Individuals When Coverage Ceases.
      In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the individual ceases to be covered under this Group Contract. CareFirst will provide the certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums).

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

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

2. Any Individual Upon Request.

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

C. Combining Information for Families.

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

6.17 Evidence of Coverage Binding on Members.

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

6.18 Payment of Contributions.

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

6.19 Complaints about CareFirst.

Members may complain to the Maryland Insurance Administration about the operation of CareFirst. Such complaints would include matters other than coverage decisions or adverse decisions as described in the benefit determinations and appeals procedures attached to this Evidence of Coverage. To complain about the operation of CareFirst, Members should contact:

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

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

The following is added to Section 2, Eligibility and Enrollment, Section 2.7 Special Enrollment Periods:

F. Special enrollment regarding Medicaid and CHIP termination or eligibility.

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

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

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


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

3. Effective Date of Coverage. If the Subscriber 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 Subscriber'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 Subscriber or Dependent is determined to be eligible for premium assistance with respect to coverage under this Evidence of Coverage.

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

Group Hospitalization and Medical Services, Inc.

[Signature]

Chester E. Burrell
President and Chief Executive Officer
Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan
An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT A

BENEFIT DETERMINATION AND
APPEAL AND GRIEVANCE PROCEDURES

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

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

These procedures only apply to claims for benefits. Notification required by these procedures will only be sent when a Member requests a benefit or files a claim in accordance with CareFirst procedures.

A. SCOPE AND PURPOSE
B. CLAIMS PROCEDURES
C. CLAIMS PROCEDURES COMPLIANCE
D. CLAIM FOR BENEFITS
E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION
F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION
G. APPEALS AND GRIEVANCES OF ADVERSE BENEFIT DETERMINATIONS
H. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS AND GRIEVANCE DECISIONS)
I. MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS AND GRIEVANCE DECISIONS)
J. FILING OF COMPLAINT AFTER RECEIPT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATION OR ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS AND GRIEVANCE DECISIONS)
K. MEMBER COMMENTS AND QUALITY COMPLAINTS
L. DEFINITIONS
M. MISCELLANEOUS

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).
However, the provision "FILING OF COMPLAINT AFTER RECEIPT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATION OR ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS AND GRIEVANCE DECISIONS)" is a requirement of the State of Maryland; therefore, a Member (also called a "Claimant" herein) of a Group where CareFirst is the claims administrator only (a Member of a "self-insured" Group) does not have this avenue available to him/her. A Member can ask his/her group administrator if he/she is a member of a self-insured Group. Finally, the timeframes herein reflect those most advantageous to the Member.

B. CLAIMS PROCEDURES

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

These Claims Procedures do not preclude an Authorized Representative, including a Health Care Provider, from acting on behalf of a Claimant in the case of a Pre-Service Claim and/or Post-Service Claim, a Claim Involving Emergency/Urgent Care as well as in pursuing an Appeal or Grievance of an Adverse Benefit Determination, Appeal Decision, Grievance Decision, and/or a Complaint to the Maryland Insurance Commissioner. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant. In the case of a Claim Involving Emergency/Urgent Care, a Health Care Provider must have knowledge of a Claimant's medical condition to 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 3 calendar days (24 hours in the case of a failure to file a Claim Involving Emergency/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 or an Authorized Representative of 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 30 calendar 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 (i.e., the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim). If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial 30-day period. The Claimant must agree in writing to this extension of time before it may become effective. In no event shall such extension exceed a period of 30 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.

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

a. Emergency/Urgent care claims. In the case of a Claim Involving Emergency/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 24 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:

i. Receipt of the specified information, or

ii. 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:

i. Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Plan or the Plan's Designee may not deny reimbursement unless: the information submitted regarding the service was fraudulent or intentionally misrepresentative; critical information required by the Plan
or the Plan's Designee was omitted such that the Plan or Plan Designee's determination would have been different had it known the critical information; a planned course of treatment for the Claimant was not substantially followed; or on the date the preauthorized service was delivered: the Claimant was not covered by the Plan; the Plan or the Plan's Designee maintained an automated eligibility verification system that was available to the Participating Provider by telephone or via the Internet; and according to the verification system, the Claimant was not covered by the Plan. 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.

ii. 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 Emergency/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 Emergency/Urgent care or not, shall be made in accordance with item F. herein, and appeal shall be governed by item H.1.a., H.1.b., or H.1.c., herein as appropriate.

c. Other claims. In the case of a claim that is not an Emergency/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.

i. 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.

Authorization of Pre-Service Claims. CareFirst will determine whether to authorize or certify a Pre-Service Claim within 2 working days following receipt of all necessary information. If information is needed to make a decision which was not included in the initial request for authorization or certification, the Plan or the Plan's Designee will notify the Health Care Provider within 3 calendar days of the initial request that additional information is needed.
ii. Post-Service Claims. In the case of a Post-Service Claim, the 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 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, the Plan or the Plan's Designee will send a Notice of receipt and status of the claim that states the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim. The 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. The Plan or the Plan's Designee shall provide a Claimant and an Authorized Representative acting on behalf of a Claimant with written or electronic Notification after it has provided oral communication of the decision to a Claimant or an Authorized Representative acting on behalf of a Claimant of any Adverse Benefit Determination. In the case of an Adverse Benefit Determination involving an Adverse Decision, 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 appeal of Adverse Benefit Determination;

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

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

h. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Emergency/Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Claimant within the timeframe prescribed in Section E.2. herein. The Claimant and Authorized Representative must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

i. That the Claimant or an Authorized Representative acting on behalf of the Claimant has a right to file a Complaint with the Commissioner within 30 working days after receipt of the Plan's Adverse Decision;

j. That a Complaint may be filed without first filing a Grievance if the Claimant, or Authorized Representative of a Claimant filing a Grievance on behalf of the Claimant can demonstrate a Compelling Reason to do so as determined by the Commissioner;

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

l. A statement that the Health Advocacy Unit is available to assist the Claimant in both mediating and filing a Grievance; and

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

2. In the case of an Adverse Benefit Determination involving a Coverage Decision, the Plan or the Plan Designee must within 30 calendar days provide the Claimant, Authorized Representative and the treating Health Care Provider, a written notice of the Coverage Decision. The statement must state in detail, in clear, understandable language, the specific factual bases for the Plan's decision and must include the following information:

   a. That the Claimant or Health Care Provider acting on behalf of the Claimant has a right to file an Appeal with the Plan or the Plan's Designee;

   b. That the Claimant or a Health Care Provider acting on behalf of the Claimant may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves a Claim for Emergency/Urgent Care which has not been rendered;

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

   d. A statement that the Health Advocacy Unit is available to assist the Claimant in both mediating and filing an Appeal; and

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

3. Adverse Benefit Determinations are made under the direction of the Chief Medical Officer.
G. APPEALS AND GRIEVANCES OF ADVERSE BENEFIT DETERMINATIONS

1. To file an Appeal or Grievance of an Adverse Benefit Determination, a Member and/or an Authorized Representative acting on a Member’s behalf, may contact CareFirst at the address and telephone number located on the Member’s ID Card; or submit a written request and any supporting record of medical documentation within 180 days of receipt of the written Notification of the Adverse Benefit Determination to the following:

Central Appeals
CareFirst BlueCross BlueShield
PO Box 17636
Baltimore, MD 21297-1636

The Health Advocacy Unit is available to assist the Claimant in both mediating and filing a Grievance. See section "J" for additional information.

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 individual who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor the subordinate of such individual;

b. In deciding a Grievance of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or Investigational, or not Medically Necessary or appropriate, the Plan or the Plan's Designee shall consult with a physician with the same specialty as the treatment under review;

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

d. Health Care Providers 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 Grievance, nor subordinates of any such individuals; and

e. In the case of a Claim Involving Emergency/Urgent Care, a request for an expedited Appeal or Grievance of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and the Plan or the Plan’s
Designee must notify the Claimant of its determination in writing within 24 hours of receipt of the expedited request for Appeal or Grievance.

H. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS AND GRIEVANCE DECISIONS)

1. The Plan or the Plan's Designee shall notify a Claimant or an Authorized Representative of its Adverse Benefit Determination on review in accordance with the following, as appropriate.
   a. Emergency/Urgent care claims. In the case of a Claim Involving Emergency/Urgent Care, the Claimant or an Authorized Representative 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 24 hours after receipt of the Claimant's or Authorized Representative's request for review of an Adverse Benefit Determination. A written notification must be provided to the Claimant and Authorized Representative within 24 hours of the orally communicated Appeal or Grievance Decision.
   b. Pre-service claims. In the case of a Pre-Service Claim, the Claimant and Authorized Representative shall be notified, in accordance with item I. herein, of the Adverse Benefit Determination on review within a reasonable period of time appropriate to the medical circumstances. Oral notification shall be provided not later than 30 days after the filing date of the Claimant's or Authorized Representative's request for review of an Adverse Benefit Determination. A written notification must be provided to the Claimant and Authorized Representative within 5 working days of the Appeal or Grievance Decision.
   c. Post-service claims. In the case of a Post-Service Claim, the Claimant and Authorized Representative shall be notified, in accordance with item I. herein, of the Adverse Benefit Determination on review within a reasonable period of time. Oral notification shall be provided not later than 60 days after the filing date of the Claimant's or Authorized Representative's request for review of an Adverse Benefit Determination. A written notification must be provided to the Claimant and Authorized Representative within 5 working days of the Appeal or Grievance Decision.

2. If the Plan or the Plan's Designee does not have sufficient information to complete its Grievance Decision, the Plan or the Plan's Designee must notify the Claimant or an Authorized Representative within five (5) working days after the Filing Date of the Appeal or Grievance by the Claimant or Authorized Representative with the Plan or the Plan's Designee. The Plan or the Plan's Designee notification shall:
   a. Notify the Claimant or Authorized Representative that it cannot proceed with reviewing the Appeal or Grievance unless additional information is provided; and
   b. Assist the Claimant or Authorized Representative in gathering the necessary information without further delay.

3. The Plan or the Plan's Designee may extend the 30-day or 60-day period required for making an Appeal or Grievance Decision under H.1.b., c. with the written consent of the Claimant or the Authorized Representative who filed the Appeal or Grievance on behalf of the Claimant. With the written consent of the Claimant or the Authorized Representative who filed the Appeal or Grievance on behalf of the Claimant, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.
4. Calculating time periods. For purposes of item H. herein, the period of time within which an Adverse Benefit Determination on review shall be made begins 5 days after the Member/Authorized Representative mails the Appeal or Grievance to the Plan or the date an Appeal or Grievance is received by the Plan or the Plan's Designee, whichever is earlier. This is without regard to whether all the information necessary to make a benefit determination on review accompanies the filing.

5. In the case of an Appeal or Grievance of Adverse Benefit Determination, 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 ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS AND GRIEVANCE DECISIONS)

The Plan or the Plan's Designee shall provide a Claimant and an Authorized Representative acting on behalf of a Claimant with written or electronic Notification after it has provided oral communication of the decision to a Claimant and an Authorized Representative acting on behalf of a Claimant of its benefit determination on review. In the case of an Appeal or Grievance 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; and

    b. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

6. In the case of a Grievance involving an Adverse Decision, a statement that includes the following information:

    a. The name, business address and business telephone number of the Medical Director who made the decision;

    b. If the Grievance is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances; and
c. That the Claimant has a right to file a Complaint with the Commissioner within 30 working days after receipt of the Grievance Decision; and

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

7. In the case of an Appeal involving a Coverage Decision, a statement that includes the following information:

   a. That the Claimant or Authorized Representative acting on behalf of the Claimant has a right to file a Complaint with the Commissioner within 60 working days after receipt of the Appeal Decision; and

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

8. Adverse Benefit Determinations and Grievance Decisions are made under the direction of the Chief Medical Officer.

J. FILING OF COMPLAINT AFTER RECEIPT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATION OR ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS AND GRIEVANCE DECISIONS)

1. a. Within 30 working days after the date of receipt of a Grievance Decision regarding an Adverse Decision or within 60 working days in the case of an Appeal Decision regarding a Coverage Decision, a Claimant or the Claimant's Authorized Representative may file a Complaint with the Commissioner for review of the Grievance Decision or Appeal Decision. A Claimant or the Claimant's Authorized Representative may file a Complaint with the Commissioner without first filing an Appeal with the Plan or the Plan's Designee only if the Coverage Decision involves a Claim Involving Emergency/Urgent Care for which care has not been rendered. A Claimant or the Claimant's Authorized Representative may file a Complaint with the Commissioner without first filing a Grievance, regarding an Adverse Decision, with the Plan or the Plan's Designee only if the Claimant or the Claimant's Authorized Representative provide sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so. The Commissioner will define by regulation the standards that will used to decide what demonstrates a compelling reason.

   The remaining provisions of this Section J. apply to Complaints regarding Adverse Decisions and Grievance Decisions.

   b. The Commissioner shall notify CareFirst of the Complaint within five working days after the date the Complaint is filed with the Commissioner.

   c. Except for a Claim Involving Emergency/Urgent Care, CareFirst shall provide to the Commissioner any information requested by the Commissioner no later than seven working days from the date CareFirst receives the request for information.

2. a. Except as provided in paragraph b. of this subsection, the Commissioner shall make a final decision on a Complaint:

   i. Within 30 working days after a Complaint is filed regarding a Pre-Service Claim;

   ii. Within 45 working days after a Complaint is filed regarding a Post-Service Claim; and
iii. Within 24 hours after a Complaint is filed regarding a Claim Involving Emergency/Urgent Care.

b. The Commissioner may extend the period within which a final decision is to be made under paragraph 2.a. of this subsection for up to an additional 30 working days if the Commissioner has not yet received:

i. information requested by the Commissioner; and

ii. the information requested is necessary for the Commissioner to render a final decision on the Complaint.

3. In cases considered appropriate by the Commissioner, the Commissioner may seek advice from an independent review organization or medical expert, for Complaints that involve a question of whether a Pre-Service Claim or a Post-Service Claim is Medically Necessary.

4. CareFirst shall have the burden of persuasion that its Adverse Benefit Determination is correct: during the review of a Complaint by the Commissioner or Designee of the Commissioner; and in any hearing held regarding the Complaint.

5. As part of the review of a Complaint, the Commissioner or Designee of the Commissioner may consider all of the facts of the case and any other evidence deemed Relevant.

6. Except as provided in subparagraph b. of the paragraph, in responding to a Complaint, CareFirst may not rely on any basis not stated in its Adverse Benefit Determination.

a. The Commissioner may allow CareFirst, a Claimant, or Authorized Representative of a Claimant to provide additional information as may be relevant for the Commissioner to make a final decision on the Complaint.

b. The Commissioner's use of additional information may not delay the Commissioner's decision on the Complaint by more than five working days.

7. The Commissioner may request the Claimant, or Authorized Representative of a Claimant to sign a consent form authorizing the release of the Claimant's medical records to the Commissioner or Designee of the Commissioner that are needed in order for the Commissioner to make a final decision on the Complaint.

8. Subject to paragraph H.1., a Claimant, or Authorized Representative of a Claimant may file a Complaint with the Commissioner if the Claimant, or Authorized Representative of a Claimant does not receive CareFirst’s Grievance Decision within the following timeframes:

a. Within 42 calendar days after the filing date of a Grievance regarding a Pre-Service Claim;

b. Within 60 calendar days after the filing date of a Grievance regarding a Post-Service Claim; and

c. Within 24 hours after the receipt of a Grievance regarding a Claim Involving Emergency/Urgent Care.
Note: the Health Advocacy Unit is available to assist the Claimant in both mediating and filing a Grievance. Contact the Health Advocacy Unit at:

Health Education and Advocacy Unit  
Consumer Protection Division  
Office of the Attorney General  
200 St. Paul Place, 16th Floor  
Baltimore, MD 21202  
410-528-1840 or 1-877-261-8807  
Fax: 410-576-6571  
E-mail: heau@oag.state.md.us

K. MEMBER COMMENTS AND QUALITY COMPLAINTS

CareFirst provides Members an opportunity to present comments or any other questions or concerns with regard to operations or administration of CareFirst, and file a quality complaint regarding the quality of any CareFirst service. All comments and quality complaints should be addressed to the Member Services Department. In the event that you are dissatisfied with a determination of the Member Services Department, the procedures listed below must be followed.

Inquiries, comments, and complaints concerning the nature of your medical care should also be addressed to the Member Services Department. That department will also assist you in filing a quality complaint after all other avenues of resolution have been exhausted.

A Member may complain to the Department of Health and Mental Hygiene, Office of Licensing and Certification Programs regarding the operation of CareFirst. The address and telephone number of the Department is available through our Member Services Department. The Member may also contact the Maryland Insurance Administration at:

Maryland Insurance Administration  
Inquiry and Investigation, Life and Health  
200 St. Paul Place, Suite 2700  
Baltimore, MD 21202  
410-468-2244

L. DEFINITIONS

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

1. **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 or Investigational or not Medically Necessary, appropriate or efficient. Adverse Benefit Determination includes both an Adverse Decision and a Coverage Decision; however, Adverse Benefit Determination, for purposes of an Adverse Decision, does not include a decision concerning a Member's eligibility status.

2. **Adverse Decision** means a utilization review determination that a proposed or delivered health care service covered under the Claimant's contract is or was not Medically Necessary, appropriate, or efficient; and may result in non-coverage of the health care service. Adverse Decision does not include a Coverage Decision.
3. **Appeal** means a protest filed by a member or a member's Authorized Representative with CareFirst under its internal appeal process regarding a Coverage Decision.

4. **Appeal Decision** means final determination by CareFirst that arises from an Appeal.

5. **Authorized Representative** means an individual, including a Health Care Provider, who acts on behalf of a Claimant in the case of a Pre-Service Claim and/or Post-Service Claim, a Claim Involving Emergency/Urgent Care as well as in pursuing an Appeal or Grievance of an Adverse Benefit Determination, Appeal Decision, Grievance Decision, and/or a Complaint to the Maryland Insurance Commissioner.

6. **Claim Involving Emergency/Urgent Care** is any claim for medical care or treatment, including a physical condition, a mental condition, or a dental condition, with respect to which the application of the time periods for making non-emergency/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. Could cause serious impairment to bodily function; or
   
   c. Cause serious dysfunction of any bodily organ or part; or
   
   d. Cause the Claimant to be in danger to self or others; or
   
   e. In the opinion of a Health Care Provider with knowledge of the Claimant's medical condition, where the absence of medical attention within 72 hours 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 Emergency/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 Health Care Provider with knowledge of the Claimant's medical condition determines is a Claim Involving Emergency/Urgent Care shall be treated as a Claim Involving Emergency/Urgent Care for purposes of these Claims Procedures.

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

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

9. **Coverage Decision** means an initial determination by CareFirst that results in non-coverage of a health care service. Coverage Decision includes nonpayment of all or any part of a claim. Coverage Decision does not include an Adverse Decision.

10. **Designee of the Commissioner** means any person to whom the Commissioner has delegated the authority to review and decide Complaints, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.
11. **Filing Date** means the earlier of:
   a. 5 days after the date of mailing; or
   b. the date of receipt.

12. **Grievance** means a protest filed by a Claimant or the Claimant's Authorized Representative through CareFirst’s internal Grievance process regarding an Adverse Decision.

13. **Grievance Decision** means a final determination by CareFirst that arises from a Grievance.

14. **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.

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

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

17. **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.

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

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

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

21. **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.

22. **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.

M. **MISCELLANOUS**

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

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

Group Hospitalization and Medical Services, Inc.

[Signature]

Chester E. Burrell
President and Chief Executive Officer
ATTACHMENT B
DESCRIPTION OF COVERED SERVICES

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

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer
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1.1 Benefits Under the Preferred Provider Plan
The Preferred Provider Plan offers two (2) levels of benefits. Members may select the benefit level at which coverage will be provided each time care is sought. Under the Preferred Provider Plan, Members may receive benefits for a particular service under either the In-Network component or the Out-of-Network component. Members may not receive duplicate benefits for the same services.

A. In-Network Benefits
When In-Network benefits apply, Members are eligible for a higher level of benefits than when Out-of-Network benefits apply. In-Network benefits apply in the following circumstances:

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

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

3. Other Circumstances
   In each of the following circumstances, benefits will be based on the appropriate Allowed Benefit for the service or supply provided. The level of benefits for these providers' services will be that shown under In-Network Benefits in the Schedule of Benefits. The Member may be responsible for amounts in excess of the Allowed Benefit, in addition to any applicable Deductibles, Coinsurance, and Copayments.
   a. The Member's Preferred Provider refers the Member to a provider who is not a Preferred Provider.
   b. The Member receives covered Emergency Services (as defined in the Evidence of Coverage) from a provider who is not a Preferred Provider.
   c. A Preferred Provider is not reasonably available.

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

1.2 Limitation on Provider Coverage
Services are covered only if the provider is an Eligible Provider. The provider must be licensed, or otherwise authorized by law, in the jurisdiction where the services are rendered. In addition, to be
covered, the services must be within the lawful scope of the services for which that provider is licensed or otherwise authorized by law. Coverage does not include services rendered to Members by:

A. An individual who is not an Eligible Provider;
B. The Member him/herself, or by the Member's Spouse, mother, father, daughter, son, brother, or sister; or,
C. Anyone who resides in the Member's home.

1.3 Referral to a Specialist or Nonphysician Specialist
A Member may request a referral to a Specialist or Nonphysician Specialist who is a Non-Preferred Provider if:

A. The Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and,
1. CareFirst does not contract with a Specialist or Nonphysician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or,
2. CareFirst cannot provide reasonable access to a Preferred Specialist or Nonphysician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, CareFirst will treat the services rendered by the Non-Preferred Specialist as if the service was provided by a Preferred Provider. The Member is responsible for the difference between the Allowed Benefit and the charge by a Non-Preferred Specialist.

A decision by CareFirst not to provide access to or coverage of treatment or health care services by a Specialist or Nonphysician Specialist as provided in this provision constitutes an adverse decision as defined in the Evidence of Coverage if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinsurance</td>
<td>For most services, once the Deductible is met (or for services without a Deductible), costs are shared based on the Coinsurance percentage of the Allowed Benefit that CareFirst must pay and the Member must pay.</td>
</tr>
<tr>
<td>Copayment</td>
<td>A Copayment is similar to coinsurance, except that Copayments are set at a fixed dollar amount, rather than as a percentage of the Allowed Benefit.</td>
</tr>
<tr>
<td>Deductible</td>
<td>The Deductible will be calculated based on the Benefit Period of the Member's coverage. Under the Preferred Provider Plan, there may be a single Deductible for In-Network and Out-of-Network services or separate Deductibles that apply to each. For most Covered Services, Members do not begin to receive benefits until they meet their Deductible.</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>If a Lifetime Maximum applies and the Member reaches the Lifetime Maximum, the Member will thereafter have either no benefit or only a limited &quot;Annual Restoration Benefit.&quot; The Schedule of Benefits provides further information on the Lifetime Maximum.</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Out-of-Pocket Limits</td>
<td>Once the Member meets the Out-of-Pocket Limits, the Member may no longer be required to pay his or her share of Copayments, Coinsurance, or Deductibles for the remainder of that Benefit Period for any services that are subject to the Out-of-Pocket Limits. Under the Preferred Provider Plan, there may be a single Out-of-Pocket Limits for In-Network and Out-of-Network services, or separate Out-of-Pocket Limits that apply to each.</td>
</tr>
</tbody>
</table>
SECTION 2
OUTPATIENT AND OFFICE SERVICES

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

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

A. Electrocardiogram;
B. Laboratory services;
C. Diagnostic x-ray services, diagnostic ultrasound services.

2.3 Preventive Services
Benefits for preventive care include the following:

A. Well Child Care
Benefits are available for infants, children, and adolescents (newborn up to the age specified in the Schedule of Benefits) for:

1. Each office visit in which a childhood or adolescent immunization, recommended by the Advisory Committee on Immunizations Practices of the Center for Disease Control, is administered, and the cost of the immunization.
2. Visits for the collection of adequate samples for hereditary and metabolic newborn screening and follow-up between birth and four (4) weeks of age, the first of which is to be collected before two (2) weeks of age.
3. Universal hearing screening of newborns provided by a hospital before discharge, or in an office or other outpatient setting.
4. Visits for and costs of age appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics.
5. Examinations including developmental assessments and parental anticipatory guidance.
6. Laboratory tests necessary to provide these services.

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

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

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

a. For men who are between forty (40) and seventy-five (75) years of age;
b. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;

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

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

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

3. Mammography Screening
   Mammography screening (by low-dose mammography) for the presence of occult breast cancer provided by a Health Care Provider that is approved by the American College of Radiology, or certified/licensed by the State of Maryland or the applicable certification/licensing laws of any State or the District of Columbia subject to the limitations, if any, listed in the Schedule of Benefits. At a minimum, benefits will be covered as follows:

   a. One (1) baseline screening for a Member thirty-five (35) to thirty-nine (39) years old;
   b. One (1) screening every twenty-four (24) months, or more frequently if recommended by a Health Care Provider, for a Member forty (40) to forty-nine (49) years old;
   c. One (1) screening every twelve (12) months for a Member fifty (50) years and over.

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

D. Chlamydia and Human Papillomavirus Screening Test

1. Definitions
   Chlamydia Screening Test means any laboratory test that specifically detects for infection by one (1) 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 (1) or more agents of the human papillomavirus and is approved for this purpose by the FDA.
   Multiple Risk Factors means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

2. Covered Services
   a. Annual Routine Chlamydia Screening Test for:
      i. Female Members who are under the age of twenty (20) years if they are sexually active; and, at least twenty (20) years old if they have Multiple Risk Factors.
      ii. Male Members who have Multiple Risk Factors.
b. A Human Papillomavirus Screening Test at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.

E. Osteoporosis Prevention and Treatment Services

1. Definitions

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

   Qualified Individual means a Member:

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

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

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

   d. With primary hyperparathyroidism; or,

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

2. Covered Benefits

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

2.4 Allergy Testing and Treatment

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

2.5 Rehabilitation Services

   A. Definitions

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

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

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

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

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

2.6 Spinal Manipulation

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

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

2.7 Habilitative Services for Children

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

Benefits for Habilitative Services are available for Dependent children under the age of nineteen (19) years and include Occupational Therapy, Physical Therapy, and Speech Therapy.

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

2.8 Therapeutic Treatment Services
Benefits are available for treatment and therapeutic services in connection with a covered procedure, including chemotherapy, electroshock therapy, radiation therapy, and radioisotope services. Benefits for high dose chemotherapy are limited to the description stated in Section 2.17, High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant.

2.9 Maternity and Related Services

A. Standard Maternity Benefits.
The following benefits are covered for all Members, subject to the limitations set forth in the Schedule of Benefits.

1. Obstetrical care for an ectopic pregnancy or miscarriage.

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

3. Postpartum Home Visits
   a. See Section, 5.3.B, Postpartum Visits in Section 5, Home Health Care Services for additional information.
   b. When CareFirst is notified of a Member's pregnancy, CareFirst will provide the Member with information, prior to the scheduled delivery date, on postpartum home visits for the mother and child, including the names of providers that are available for postpartum home visits.

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

B. Extended Maternity and Related Coverage
   Consult the Schedule of Benefits to determine to whom and the extent to which these services are provided.

   1. Outpatient obstetrical care for a pregnancy and complications of pregnancy, including prenatal and postnatal office visits and Ancillary Services provided during those visits.

   2. Inpatient hospital visits if the Member does not deliver during that episode of care.

   3. Professional services during a covered hospitalization for delivery rendered to mother and newborn.

   4. Medically Necessary prenatal laboratory tests and diagnostic services as determined by CareFirst, including but not limited to, ultrasound services, fetal stress and non-stress tests and amniocentesis.

   5. Elective abortions.

2.10 Contraceptive Devices and Drugs
   Coverage will be provided for the insertion or removal, and any Medically Necessary examination associated with the use of contraceptive devices or drugs. Benefits are available to the same extent as benefits provided for outpatient medical care, outpatient surgical care and diagnostic services.

   Benefits for contraceptive devices and drugs described herein are covered under Prescription Drug Benefits Rider attached to this Evidence of Coverage.

2.11 Infertility Services
   Benefits are provided for Medically Necessary, non-Experimental/Investigational artificial insemination/intrauterine insemination and in-vitro fertilization, and associated services. Benefits are limited to:

   A. Infertility counseling;

   B. Testing;
C. Artificial insemination/intrauterine insemination when:

1. The Member has had a fertility examination that resulted in a physician’s recommendation advising artificial insemination;

2. The Member's Spouse's sperm is used; and,

3. Prior authorization for the treatment was obtained from CareFirst.

Any cost associated with the collection of the Member's Spouse's sperm will not be covered unless the Spouse is also a Member.

D. In-vitro Fertilization (IVF)

1. Benefits (including gamete and zygote intra-fallopian transfer) are provided for outpatient expenses arising from IVF procedures approved by the federal Food and Drug Administration and 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 Fertility Society minimal standards for IVF programs.

2. Benefits are available when:

   a. Prior authorization for the treatment was obtained from CareFirst;

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

   c. The Member and the Member's Spouse have a history of Infertility of at least two (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); or,

      iv. Abnormal male factors, including oligospermia, contributing to the Infertility; and,

   d. The Member has been unsuccessful through less costly Infertility treatment for which coverage is available.

3. Benefits for IVF services are limited to:

   a. Three (3) attempts per live birth; and,

   b. A Lifetime Maximum benefit of one hundred thousand dollars ($100,000).

2.12 Blood and Blood Products

Benefits are available for blood and blood products (including derivatives and components) that are not replaced by or on behalf of the Member.
2.13 **Outpatient Surgical Procedures**
Benefits are available for surgical procedures performed by Health Care Practitioners on an outpatient basis.

2.14 **Anesthesia Services for Medical or Surgical Procedures**
Benefits are available for the administration of general anesthesia in connection with a covered medical or surgical procedure. To be eligible for separate coverage, a Health Care Practitioner other than the operating surgeon or assistant at surgery must administer the anesthesia. For example, a local anesthetic used while performing a medical or surgical procedure is not generally viewed as a separately covered charge.

2.15 **Outpatient Care**
Benefits are available for the following outpatient services rendered in the outpatient department of a hospital, in an ambulatory surgical facility, or other facility in connection with a medical or surgical procedure covered under Section 2, Outpatient and Office Services of this Description of Covered Services.

A. Use of operating room and recovery room;
B. Use of special procedure rooms;
C. Laboratory, x-ray, and machine tests;
D. Hemodialysis;
E. Chemotherapy and radiation therapy (benefits for high dose chemotherapy are limited to any stated in Section 2.17, High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant of this Description of Covered Services);
F. Cardiac Rehabilitation

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

2. Conditions and Limitations
   Subject to the limitations stated in the Schedule of Benefits. In addition, services must be provided at a CareFirst approved place of service equipped and approved to provide Cardiac Rehabilitation. Benefits will not be provided for maintenance programs.

2.16 **Organ and Tissue Transplants**
Prior authorization is required for transplant services. Prior authorization will be granted only upon receipt of a written request from a physician. CareFirst must approve the hospital/facility at which the transplant will be performed. Benefits for organ and tissue transplants are limited to the following procedures:

A. Kidney, cornea, bone and skin (for grafting or for any other Medically Necessary purposes);
B. Heart; combined heart and lung; single lung; double lung; pancreas, when performed simultaneously with a kidney transplant; liver. Prior to commencing a course of treatment for these procedures, the Member must obtain CareFirst's written approval for
both the procedure and the facility where the transplant will be done. No benefits will be
provided for the facility, the procedure, or any resulting complication if the Member did
not receive CareFirst's advance written approval.

C. Autologous bone marrow.

**NOTE:** Autologous bone marrow transplant or stem cell transplant in connection with
covered high dose chemotherapy treatment are covered only as described in Section 2.17.

D. Allogeneic bone marrow.

**NOTE:** Allogeneic bone marrow transplant or stem cell transplant in connection with
covered high dose chemotherapy treatment are covered only as described in Section 2.17.

If the Member is the recipient of a covered organ/tissue transplant, CareFirst will cover the Donor
Services to the extent that the services are not covered under any other health insurance plan or
contract. If the Member is a donor and the recipient is not a Member, no benefits are available for
either the Member or the recipient.

Donor Services mean services covered under this Evidence of Coverage which are related to the
transplant surgery, including evaluating and preparing the actual donor, regardless of whether the
transplant is attempted or completed, and recovery services after the donor procedure, which are
directly related to donating the organ or tissue.

All charges directly or indirectly relating to the transplantation of non-human organs are excluded.

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

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

2.18 Clinical Trial Patient Cost Coverage

A. Definitions

**Cooperative Group** means a formal network of facilities that collaborate on research
projects and have an established NIH-approved peer review program operating within the
Group. Cooperative Group includes the National Cancer Institute Clinical Cooperative
Group, National Cancer Institute Community Clinical Oncology Program, AIDS Clinical
Trials Group, and Community Programs for Clinical Research in AIDS.

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

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

### B. Covered Services

1. Benefits for Patient Cost to a Member in a clinical trial will be provided if the Member's participation in the clinical trial is the result of:
   a. Treatment provided for a life-threatening condition; or,
   b. Prevention, early detection, and treatment studies on cancer.

2. Coverage for Patient Cost will be provided only if:
   a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or,
   b. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening condition;
   c. The treatment is being provided in a clinical trial approved by one of the National Institutes of Health, an NIH Cooperative Group, an NIH Center, the FDA in the form of an Investigational new drug application, the federal Department of Veterans Affairs, or an institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office Of Protection From Research Risks of the NIH;
   d. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
   e. There is no clearly superior, non-Investigational treatment alternative; and,
   f. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Investigational alternative.
   g. Services have been authorized by CareFirst.

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

### 2.19 Morbid Obesity

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

Morbid Obesity means:

1. A Body Mass Index that is greater than forty (40) kilograms per meter squared; or,
2. A Body Mass Index equal to or greater than thirty-five (35) kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

B. Covered Benefits
   Benefits are provided for Medically Necessary surgical services for the treatment of Morbid Obesity, as determined by CareFirst. The procedures must be recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity and consistent with guidelines approved by the National Institutes of Health. Benefits are subject to the same terms and conditions as other Medically Necessary surgical procedures.

2.20 Diabetes Equipment and Supplies, and Self-Management Training
   A. If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified Health Care Provider whose scope of practice includes diabetes education or management.
   B. Coverage information for diabetic equipment and supplies is located in Section 8, Medical Devices and Supplies.

2.21 Dental Services
   A. Accidental Injury
      1. Covered Benefits
         Dental benefits will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if the injury did not arise while or as a result of biting or chewing, and treatment is commenced within six (6) months of the injury or, if due to the nature of the injury, treatment could not begin within six (6) months of the injury, treatment began within six (6) months of the earliest date that it would be medically appropriate to begin such treatment.
      2. Conditions and Limitations
         Benefits are limited to restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury. Except as listed here, or in Section 2.21C describing benefits for the treatment of cleft lip or cleft palate or both, dental care is excluded from coverage. Benefits for oral surgery are described below.

   B. General Anesthesia for Dental Care
      Benefits for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a Member under the following circumstances:
      1. If the Member is:
         a. Seven (7) years of age or younger, or developmentally disabled;
b. An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member; and,

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

2. Or, if the Member is:

a. Seventeen (17) years of age or younger;

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

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

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

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

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

   a. A fully accredited specialist in pediatric dentistry;

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

   c. A dentist who has been granted hospital privileges.

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

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

7. Prior authorization for the anesthesia services was obtained from CareFirst.

C. Treatment for Cleft Lip or Cleft Palate or Both

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

2.22 Oral Surgery

A. Benefits for oral surgery include:

1. Medically Necessary procedures, as determined by CareFirst, to attain functional capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or exostoses, or drain abscesses with cellulitis and are performed lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, and jaws.

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

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

B. Medically Necessary surgical treatment, as determined by CareFirst, for Temporomandibular Joint Syndrome (TMJ). All other treatments or procedures for the treatment of TMJ are excluded.

C. All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.

2.23 Reconstructive Breast Surgery

A. Definitions

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

Reconstructive Breast Surgery means surgery performed as a result of a Mastectomy to reestablish symmetry between two (2) breasts. Reconstructive Breast Surgery includes augmentation mammoplasty, reduction mammoplasty, and mastoplexy.

B. Covered Benefits

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

2.24 Reconstructive Surgery

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

2.25 Emergency Services

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

2.26 Ambulance Services

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

If the Member is outside the United States and requires treatment by a medical professional, benefits will be provided to transport the Member to the nearest location where more appropriate medical care is available. Benefits include air or ground ambulance services, when Medically Necessary.
SECTION 3
INPATIENT HOSPITAL SERVICES

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

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

B. Physician and Medical Services
   Inpatient physician and medical services provided by or under the direction of the attending Healthcare Practitioner, including:
   1. Inpatient Healthcare Practitioner visits.
   2. Consultations by Healthcare Practitioner Specialists.
   3. Intensive care services.
   4. Rehabilitation Services.
   5. Respiratory therapy, radiation therapy and chemotherapy services.
   6. Anesthesia services and supplies.
   7. Diagnostic procedures, laboratory tests and x-ray services.
   8. Medically Necessary Ancillary Services rendered to the Member.

C. Services and Supplies
   Related inpatient services and supplies that are not Experimental/Investigational, as determined by CareFirst, and ordinarily furnished by the hospital to its patients, including:
   1. The use of:
      a. Operating rooms;
      b. Treatment rooms; and
      c. Special equipment in the hospital.
   2. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.
   3. Medical and surgical supplies.
   4. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administrations of infusions are covered.
   5. Surgically implanted Prosthetic devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants and pacemakers. Available benefits under this provision do not include items such as artificial
limbs or eyes, hearing aids, or other external prosthetics, which may be provided under other provisions of the Description of Covered Services.

6. Medical social services.

3.2 Number of Hospital Days Covered

Provided the conditions, including the requirements below, are met and continue to be met, as determined by CareFirst, hospital benefits for Inpatient Hospital Services will be provided as follows:

A. Hospitalization for Rehabilitation

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

1. Is required primarily for Physical Therapy or other rehabilitative care; and
2. Would not be Medically Necessary based solely on the Member's need for inpatient acute care services other than for rehabilitation.

B. Inpatient Coverage Following a Mastectomy

Coverage will be provided for a minimum hospital stay of not less than:

1. Forty-eight (48) hours following a radical or modified radical Mastectomy; and
2. Twenty-four (24) hours following a partial Mastectomy with lymph node dissection for the treatment of breast cancer.

C. Hysterectomies

Coverage will be provided for vaginal hysterectomies and abdominal hysterectomies. Coverage includes a minimum stay in the hospital of:

1. Not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy; and
2. Not less than forty-eight (48) hours for a vaginal hysterectomy.

In consultation with the Health Care Practitioner, the Member may elect to stay less than the minimum prescribed above when appropriate.

D. Childbirth

Inpatient hospital services are covered under the mother's coverage during the mother's covered hospitalization. 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.

If the delivery occurs in the hospital, the length of stay begins at the time of the delivery. If the delivery occurs outside of the hospital the length of stay begins upon admission to the hospital. The Member and Health Care Practitioner may agree to an early discharge.
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. Non-routine care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as a Member in the newborn's own right. Section 2.6 in the Evidence of Coverage describes the steps, if any, necessary to enroll a newborn Dependent Child.

3.3 Other Inpatient Services
Benefits are available for all other care in the nature of usual hospital services that are Medically Necessary for the care and treatment of the patient, provided that those services cannot be rendered in an outpatient setting and are not otherwise specifically excluded.
SECTION 4
SKILLED NURSING FACILITY SERVICES

4.1 Covered Skilled Nursing Facility Services

A. Definitions

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

Qualified Skilled Nursing Facility means a licensed facility that is approved for participation as a Skilled Nursing Facility under Medicare, certified as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations, its successor, or the applicable state regulatory agency. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism. Inpatient skilled nursing is for patients who are medically fragile with limited endurance and require a licensed health care professional to provide skilled services in order to ensure the safety of the patient and to achieve the medically desired result. Inpatient skilled nursing services must be provided on a 24 hour basis, 7 days a week.

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

B. Covered Benefits

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

1. Room and board in a semiprivate room;

2. The following inpatient physician and medical services if CareFirst determines that the Health Care Practitioner rendered services to the Member and such services were medically required to diagnose or treat the Member's condition:
   a. Health Care Practitioner visits during the facility stay, one (1) per day. Benefits are available for more than one (1) inpatient visit per day if warranted by the complexity of the medical condition.
   b. Consultation by another Health Care Practitioner when additional skilled care is required because of the complexity of the Member's condition.

3. Services and supplies ordinarily furnished by the facility to inpatients for diagnosis or treatment, including:
   a. Use of special equipment in the facility;
   b. Drugs, medications, solutions, biological preparations, and medical supplies used while the Member is an inpatient in the facility.

4.2 Conditions for Coverage

Skilled Nursing Facility care must be authorized or approved by CareFirst as meeting the following conditions for coverage:
A. The admission to the Qualified Skilled Nursing Facility must be a substitute for hospital care (i.e., if the Member were not admitted to a Skilled Nursing Facility, he or she would have to be admitted to a hospital).

B. The Member must require Skilled Nursing Care or skilled Rehabilitation Services which are:
   1. Required on a daily basis;
   2. Not Custodial; and,
   3. Only provided on an inpatient basis.

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

4.3 Custodial Care

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

A. Examples of Custodial Care include:
   1. Assistance in performing the activities of daily living, such as feeding, dressing, and personal hygiene;
   2. Administration of oral medications, routine changing of dressing, or preparation of special diets; and,
   3. Assistance in walking or getting in or out of bed.

B. Services may be deemed Custodial even if:
   1. The Member cannot provide this care for himself or herself because of age or illness;
   2. There is no one in the Member's household who can perform these services for the Member;
   3. The care is ordered by a physician;
   4. The care is necessary to maintain the Member's present condition; or,
   5. Covered by Medicare.
SECTION 5
HOME HEALTH CARE SERVICES

5.1 Covered Home Health Care Services

A. Definitions

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

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

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

**Home Health Care Visits**

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

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

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

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

5.2 Limitations

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

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

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

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

D. The need for Home Health Care Services must not be Custodial in nature (see Section 10, Exclusions and Limitations).

E. Services of a home health aide, medical social worker, or registered dietician must be performed under the supervision of a licensed professional nurse (R.N. or L.P.N.).
F. All services must be arranged and billed by the Qualified Home Health Agency. Providers may not be retained directly by the Member.

5.3 **Number of Home Health Care Visits.**

A. **Home Health Care Visits Following Mastectomy or Surgical Removal of a Testicle.** For a Member who receives less than 48 hours of inpatient hospitalization following a mastectomy or the surgical removal of a testicle, or who undergoes a mastectomy or the surgical removal of a testicle on an outpatient basis, benefits will be provided for:

1. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and

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

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

1. For a mother and newborn child who have a shorter hospital stay than that provided under Section 3.2.D, Number of Hospital Days Covered, benefits will be provided for:
   a. one (1) home visit scheduled to occur within twenty-four (24) hours after hospital discharge; and
   b. an additional home visit if prescribed by the attending provider.

2. For a mother and newborn child who remain in the hospital for at least the length of time provided under Section 3.2.D, Number of Hospital Days Covered, benefits will be provided for a home visit if prescribed by the attending provider.

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

4. Copayments, Coinsurance amounts and Deductibles, if any, will not be applied to this benefit.

C. All other Home Health Care Visits will be provided up to the maximum visit limit, if any, stated in the Schedule of Benefits.
SECTION 6
HOSPICE CARE SERVICES

6.1 Covered Hospice Care Services

A. Definitions

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

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

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

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

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

Qualified Hospice Care Program means a coordinated, interdisciplinary program provided by a hospital, Qualified Home Health Agency, or other Health Care Facility that is licensed or certified by the state in which it operates as a hospice program and is designed to meet the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement period.

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

B. Covered Benefits

Benefits will be provided for the services listed below when provided by a Qualified Hospice Care Program. Coverage for hospice care services is subject to certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements.

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

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

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

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

5. Services, visits, medical/surgical equipment, or supplies, including equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member;
6. Laboratory test and x-ray services;
7. Medically Necessary ground ambulance, as determined by CareFirst;
8. Respite Care will be limited to an annual benefit of fourteen (14) days;
9. Inpatient care is limited to a Lifetime Maximum of thirty (30) days per Member;
10. Family Counseling will be provided to the Immediate Family and the Family Caregiver before the death of the terminally ill Member, when authorized or approved by CareFirst;
11. Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Member for the six (6) month period following the Member's death or fifteen (15) visits, whichever occurs first.

6.2 Conditions for Coverage
Hospice care services must be certified by CareFirst, provided by a Qualified Hospice Care Program, and meet the following conditions for coverage:

A. The Member must have a life expectancy of six (6) months or less;
B. The Member's attending physician must submit a written hospice care services Plan of Treatment to CareFirst;
C. The Member must meet the criteria of the Qualified Hospice Care Program;
D. The need and continued appropriateness of hospice care services must be certified by CareFirst as meeting the criteria for coverage in accordance with CareFirst utilization management requirements.

6.3 Hospice Eligibility Period
The hospice eligibility period begins on the first date hospice care services are rendered and terminates one hundred eighty (180) days later or upon the death of the terminally ill Member, if sooner. If the Member requires an extension of the eligibility period, the Member or the Member's representative must notify CareFirst in advance to request an extension of benefits. CareFirst reserves the right to extend the eligibility period on an individual case basis if CareFirst determines that the Member's prognosis and continued need for services are consistent with a program of hospice care services.
7.1 Definitions

Mental Illness and Emotional Disorders are broadly defined as including any mental disorder, mental illness, psychiatric illness, mental condition, or psychiatric condition (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis, or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions, and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC). Benefits for services required in connection with the diagnosis, care, or treatment of Mental Illness and Emotional Disorders will be provided solely under and subject to the terms and conditions described in this section.

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

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

Qualified Treatment Facility means a non-residential facility or distinct part of a facility that is licensed in the jurisdiction(s) in which it operates and accredited by the Joint Commission of Accreditation of Healthcare Organizations, its successor, or the applicable state regulatory agency, as a substance abuse and alcohol treatment facility and which operates a program for the treatment and rehabilitation of Alcohol and Drug Abuse.

7.2 Outpatient Mental Health and Substance Abuse Services

Coverage will be provided for the diagnosis, care, and treatment of Mental Illness, Emotional Disorders, and Substance Abuse, subject to the terms and conditions outlined and in accordance with the limits described in the Schedule of Benefits, as follows:

A. Diagnosis and treatment for Mental Illness and Emotional Disorders at physician offices, other outpatient medical offices and facilities, and in Qualified Partial Hospitalization Programs.

B. Diagnosis and treatment for Substance Abuse, including detoxification and Rehabilitative Services as an outpatient in a covered alcohol or drug rehabilitation program or Qualified Partial Hospitalization Program.

C. Psychological and neuropsychological testing for diagnostic purposes, which are rendered to treat Mental Illness, Emotional Disorders, and Substance Abuse.

D. Other covered medical and medical Ancillary Services will be covered for conditions related to Mental Illness, Emotional Disorders, and Substance Abuse on the same basis as other covered medical conditions.

E. Office visits for medication management in connection with Mental Illness, Emotional Disorders, and Substance Abuse will be covered on the same basis as other covered medical conditions.
F. Benefits are available for partial hospitalization in a Qualified Partial Hospitalization Program, subject to the limits described in the Schedule of Benefits. Utilization management approval is not required for methadone maintenance treatment.

7.3 Inpatient Mental Health and Substance Abuse Services

Benefits are available for inpatient treatment of Mental Illness, Emotional Disorders, and Substance Abuse. Coverage for inpatient services is subject to CareFirst certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements. When the Member is an inpatient in a hospital or other CareFirst-approved Health Care Facility for treatment of Mental Illness, Emotional Disorders, and Substance Abuse benefits will be covered as follows:

A. Hospital benefits will be provided, as described in Section 3, Inpatient Hospital Services of this Description of Covered Services, on the same basis as a medical (non-Mental Health or Substance Abuse) admission, up to the limits described in the Schedule of Benefits, if any, for Inpatient Mental Health and Substance Abuse Services.

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

The following Inpatient Health Care Practitioner benefits apply if the Member is an inpatient in a hospital covered under inpatient hospitalization benefits following CareFirst certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements:

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

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

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

C. Benefits are available for diagnosis and treatment for Substance Abuse, including inpatient detoxification and Rehabilitative Services in an acute care hospital or Qualified Treatment Facility. Members must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by CareFirst.

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

7.4 Residential Crisis Services

A. Definitions

Residential Crisis Services means 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. Covered Benefits
Notwithstanding any term to the contrary, benefits are provided for Medically Necessary Residential Crisis Services. These services must receive prior authorization. The Member or Provider should obtain approval prior to services being rendered. If there is a benefit reduction under the plan for failure to obtain prior authorization for mental health care, then that reduction will be applied to benefits for these services.

Any Deductible, Coinsurance, or Copayment due under this Evidence of Coverage for facility charges, professional services and office visits will be applied to these services, as applicable.

7.5 Conditions and Limitations
Coverage is subject to CareFirst certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements.
SECTION 8
MEDICAL DEVICES AND SUPPLIES

8.1 Definitions

Durable Medical Equipment means equipment which:
A. Is primarily and customarily used to serve a medical purpose;
B. Is not useful to a person in the absence of illness or injury;
C. Is ordered or prescribed by a physician or other qualified practitioner;
D. Is consistent with the diagnosis;
E. Is appropriate for use in the home;
F. Is reusable; and
G. Can withstand repeated use.

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

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

Low Protein Modified Food Product means a food product that is:
A. Specially formulated to have less than 1 gram of protein per serving; and
B. Intended to be used under the direction of a physician for the dietary treatment of an Inherited Metabolic Disease.

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

Medical Food means a food that is:
A. Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
B. Formulated to be consumed or administered under the direction of a physician.

Medical Device means Durable Medical Equipment, Hearing Aid for a Minor Child, Medical Food, Low Protein Modified Food Product, Medical Supplies, Orthotic Device and Prosthetic Device.

Medical Supplies means items that:
A. Are primarily and customarily used to serve a medical purpose;
B. Are not useful to a person in the absence of illness or injury;
C. Are ordered or prescribed by a physician or other qualified practitioner;
D. Are consistent with the diagnosis;
E. Are appropriate for use in the home;
F. Cannot withstand repeated use; and
G. Are usually disposable in nature.

Orthotic Device means orthoses and braces which:
A. Are primarily and customarily used to serve a therapeutic medical purpose;
B. Are prescribed by a Health Care Provider;
C. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;
D. May be purely passive support or may make use of spring devices;
E. Include devices necessary for post-operative healing.

Prosthetic Device means a device which:
A. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or
B. Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
C. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
D. Is prescribed by a Health Care Provider; and
E. Is removable and attached externally to the body.

8.2 Covered Services

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

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

B. Hair Prosthesis

1. 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, subject to the limitations stated in the Schedule of benefits.

2. Benefits for hair prosthesis do not accrue to the annual benefit maximum, if any, for medical devices and supplies.
C. Hearing Aids for Minor Children
Benefits are available for the following services, subject to the limitations stated in the Schedule of Benefits:

1. One Hearing Aid for a Minor Child, 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.

3. Benefits for Hearing Aids for a Minor Child do not accrue to the annual benefit maximum, if any, for medical devices and supplies.

D. Medical Foods and Low Protein Modified Food Products

1. Medically Necessary Medical Foods and Low Protein Modified Food Products for the treatment of metabolic diseases and inborn deficiencies of amino acid metabolism when ordered by a Health Care Practitioner qualified to provide the diagnosis and treatment in the field of metabolic disorders, as determined by CareFirst.

2. Benefits for Medical Foods and Low Protein Modified Food Products do not accrue to the annual benefit maximum, if any, for medical devices and supplies.

E. Amino Acid-Based Elemental Formulas. Coverage for Medically Necessary amino acid-based elemental formulas, regardless of delivery method, will be provided for the diagnosis and treatment of:

1. Immunoglobulin-E and non-immunoglobulin-E mediated allergies to multiple food proteins;

2. Severe food protein induced enterocolitis syndrome;

3. Eosinophilic disorders, as evidenced by the results of a biopsy; and

4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

F. Medical Supplies

G. Diabetes Equipment and Supplies

1. Coverage will be provided for all Medically Necessary and medically appropriate equipment and diabetic supplies, necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

2. Benefits for diabetic equipment and supplies do not accrue to the annual benefit maximum, if any, for medical devices and supplies.

3. Benefits for insulin syringes and other diabetic supplies described herein are covered under Prescription Drug Benefits Rider attached to this Evidence of Coverage. All other diabetic equipment is covered as a medical device or supply.

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

I. Orthotic Devices and 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.

J. Breast Prostheses.
External breast prosthesis (including a surgical brassiere) following medically necessary mastectomy.

8.3 Repairs
Benefits for the repair, maintenance, or replacement of Covered Durable Medical Equipment are limited as follows:

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

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

C. Replacement coverage is limited to once every two (2) years due to irreparable damage and/or normal wear, or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family member are not covered.

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

8.5 Responsibility of CareFirst
CareFirst will not be liable for any claim, injury, demand, or judgment based on tort or other grounds (including warranty of equipment), arising out of or in connection with the rental, sale, use, maintenance, or repair of prosthetic devices, corrective appliances or durable medical equipment, whether or not covered under this Evidence of Coverage.
Failure to meet the requirements of the Utilization Management Program may result in a reduction or denial of benefits even if the services are Medically Necessary. Prior authorization from CareFirst will be obtained by Preferred Providers and Participating Providers located in the CareFirst Service Area. It is the Member's responsibility to obtain prior authorization when services are rendered outside of the CareFirst Service Area and for services rendered by Non-Participating Providers except for Outpatient Mental Health and Substance Abuse Services.

9.1 Utilization Management
Benefits are subject to review and approval under utilization management requirements established by CareFirst. Through utilization management, CareFirst will 1) review Member care and evaluate requests for approval of coverage in order to determine the Medical Necessity for the services; 2) review the appropriateness of the hospital or facility requested; and, 3) determine the approved length of confinement or course of treatment in accordance with CareFirst-established criteria. In addition, utilization management may include additional aspects such as prior authorization, second surgical opinion and/or preadmission testing requirements, concurrent review, discharge planning, and case management. Failure or refusal of the Member to comply with notice requirements and other utilization management authorization and approval procedures may result in the denial of, or a significant reduction, in benefits. If coverage is reduced or excluded for failure to comply with utilization management requirements, the reduction or exclusion may be applied to all services (other than Medically Necessary Ancillary Services) related to the treatment, admission, or portion of the admission for which utilization management requirements were not met. The terms that apply to a Member's coverage for failure to comply with utilization management requirements are stated in the Schedule of Benefits.

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

9.3 Member Responsibility
If the Member is outside of the CareFirst Service Area, or care is rendered by a Non-Participating Provider, the Member is responsible for all utilization management requirements. It is the Member's responsibility to assure that providers associated with the Member's care cooperate with utilization management requirements. This includes initial notification in a timely manner, responding to CareFirst inquiries and, if requested, allowing CareFirst representatives to review medical records on-site or in CareFirst offices. If CareFirst is unable to conduct utilization reviews, Member benefits may be reduced or excluded from coverage. Prior authorization is not required for outpatient Mental Health and Substance Abuse Services rendered by a Non-Participating Provider.

9.4 Procedures
To initiate utilization management review, the Member may directly contact CareFirst or may arrange to have notification given by a family member or by the provider that is involved in the Member's care. However, these individuals will be deemed to be acting on the Member's behalf. If the Member and/or the Member's representatives fail to contact CareFirst as required, or provide inaccurate or incomplete information, benefits may be reduced or excluded.

Members should share the utilization management requirements with family members and other responsible persons who could arrange for care on the Member's behalf in accordance with these
provisions in case the Member is unable to do so when necessary. CareFirst will provide additional information regarding utilization management requirements and procedures, including telephone numbers and hours of operation, at the time of enrollment and at any time upon the Member's request.

9.5 Services Subject to Utilization Management

It is the Member's responsibility to obtain prior authorization when services are rendered outside of the CareFirst Service Area and for services rendered by Non-Participating Providers, except for outpatient Mental Health and Substance Abuse Services.

A. Hospital Inpatient Services

All hospitalizations (except for maternity admissions as specified) require prior authorization. The Member must contact CareFirst (or have the provider contact CareFirst) at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because it is not feasible to delay the admission for five (5) business days due to the Member's medical condition, CareFirst must receive notification of the admission as soon as possible but in any event within forty-eight (48) hours following the beginning of the admission or by the end of the first business day following the beginning of the admission, whichever is later. Note the following:

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

2. Ancillary Services
   Benefits for inpatient Ancillary Services will not be denied solely based on the fact that the denial of the hospitalization day was appropriate. Instead, a denial of inpatient Ancillary Services shall be based on the Medical Necessity of the specific Ancillary Service. In determining the Medical Necessity of an Ancillary Service performed on a denied hospitalization day, consideration shall be given to the necessity of providing the Ancillary Service in the acute setting for each day in question.

3. For emergency admissions, CareFirst may not render an adverse decision solely because CareFirst was not notified of the emergency admission within the prescribed period of time after that admission if the Member's condition prevented the hospital from determining the Member's insurance status or CareFirst's emergency admission requirements.

B. Inpatient Mental Health and Substance Abuse Services

The Member must contact CareFirst (or have the provider contact CareFirst) at least five (5) business days prior to an elective or scheduled admission. If the admission cannot be scheduled in advance because care is required immediately due to the Member's condition, CareFirst must receive notification of the admission as soon as possible but in any event within forty-eight (48) hours following the beginning of the admission or by the end of the first business day following the beginning of the admission, whichever is later.

For emergency admissions, CareFirst may not render an adverse decision solely because CareFirst was not notified of the emergency admission within the prescribed period of time after that admission if the Member's condition prevented the hospital from determining the Member's insurance status or CareFirst's emergency admission requirements.

In the case of an inpatient mental health and/or substance abuse admission of a Member who is determined by the Member's physician or psychologist, in conjunction with a member of the hospital staff who has admitting privileges, to be in imminent danger to
himself/herself or others, CareFirst may not render an adverse authorization determination for an involuntary admission until seventy-two (72) hours after the admission.

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

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

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

1. Home Health Care Services;
2. Skilled Nursing Facility Services;
3. Hospice Care Services;
4. Habilitative Services;
5. Clinical trials;
6. General anesthesia for dental care;
7. Residential Crisis Services; and,
8. Treatment of Infertility, limited to:
   a. Artificial insemination;
   b. Intrauterine insemination;
   c. Assisted reproductive technology, including:
      i. In-vitro fertilization (IVF);
      ii. Gamete intrafallopian transfer (GIFT);
      iii. Zygote intrafallopian transfer (ZIFT);

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

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

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

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

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

B. Education of individual/family regarding disease, treatment compliance, and self-care techniques;
C. Help with organization of care, including arranging for needed services and supplies;

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

E. Referral of Member to community resources.

9.9 Appealing a Utilization Management Decision
If the Member or Member’s provider disagrees with a utilization management decision, CareFirst will review the decision upon request. A utilization management appeal will be reviewed and decided upon by the CareFirst Medical Director or Associate Medical Director not involved in the initial denial decision. If necessary, the Medical Director or Associate Medical Director will discuss the Member’s case with the Member’s physician and/or request the opinion of a specialist board certified in the same specialty as the treatment under review. Any non-certification or penalty may be appealed. Additional information is provided in Benefit Determination and Appeal and Grievance Procedures of this Evidence of Coverage on how to appeal a utilization management decision.
SECTION 10
EXCLUSIONS AND LIMITATIONS

10.1 General Exclusions
Coverage is not provided for the following:

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

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

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

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

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

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

G. Any type of dental care (except treatment of accidental injuries, oral surgery, and cleft lip or cleft palate or both, as described in this Description of Covered Services) including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth, or any other dental services or supplies, unless provided in a separate rider or amendment to this Evidence of Coverage. Benefits for oral surgery are in Section 2.22 of the Description of Covered Services. All other procedures involving the teeth or areas surrounding the teeth, including shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.

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

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

J. Any Prescription Drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment or unless the Prescription Drug is specifically identified as covered. Take-home prescriptions or medications, including self-administered injections
which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, even though they may be dispensed or administered in a physician or provider office or facility, unless the take-home prescription or medication is specifically identified as covered. Benefits for Prescription Drugs may be available through a rider or endorsement purchased by the Group and attached to this Evidence of Coverage.

K. All non-Prescription Drugs, medications, biologicals, and Over-the-Counter disposable supplies routinely obtained and self-administered by the Member, except for the CareFirst benefits described in the Description of Covered Services.

L. Foods or formulas consumed as a sole source of or supplemental nutrition, except as listed under Covered Services in the Description of Covered Services.

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

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

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

P. Medical or surgical treatment for obesity and weight reduction, except in the instance of Morbid Obesity.

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

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

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

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

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

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

W. 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.
X. Private Duty Nursing.

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

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

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

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

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

BB. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy, excluding no fault insurance.

CC. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst, and services listed under Section 2.16, Transplants of this Description of Covered Services), whether or not recommended by an Eligible Provider.

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

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

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

GG. Services, drugs, or supplies the Member receives without charge while in active military service.

HH. Habilitative Services delivered through early intervention and school services.

II. Custodial Care.

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

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

LL. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.
Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

10.2 Infertility Services
Benefits will not be provided for the following:

A. Any costs associated with cryopreservation, storage or thawing of sperm, egg, or embryo;
B. IVF procedures and any related testing or service that includes the use of donor sperm or donor eggs;
C. Any costs associated with donor eggs or donor sperm;
D. For domestic partners or common law spouses, except in those states that legally recognize those unions;
E. Costs associated with the utilization of any surrogate or gestational carrier service;
F. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures, with or without reversal.
G. Medical or surgical treatment for Infertility, unless otherwise specified in Covered Services under the Description of Covered Services.
H. All self-administered fertility drugs. Benefits for Prescription Drugs may be available through a rider or endorsement purchased by the Group and attached to this Evidence of Coverage. Coverage will be provided for self-administered in-vitro fertilization (IVF) drugs if the Group does not provide a Prescription Drug Benefits Plan.

10.3 Transplants
Benefits will not be provided for the following:

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts that are covered under the Description of Covered Services.
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. Donor search services.
F. Any organ transplant or procurement done outside the United States unless authorized or approved by CareFirst.
G. Any service, supply, or device related to a transplant that is not listed as a benefit in the Description of Covered Services.

10.4 Inpatient Hospital Services
Coverage is not provided (or benefits are reduced, if applicable) for the following:
A. Private room, unless Medically Necessary and/or 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 Health Care Facility admission or any portion of a Health Care Facility admission (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage. See Utilization Management Non-Compliance provision in the Schedule of Benefits for exclusion of services or limitation of benefits, if any, for failure to comply with Utilization Management requirements.

D. Private Duty Nursing.

10.5 Home Health Care Services
Coverage is not provided for:

A. Private Duty Nursing.

B. Custodial Care.

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

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

B. Financial and legal counseling.

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

D. Reimbursement for volunteer services.

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

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

G. Custodial Care, domestic, or housekeeping services.

10.7 Medical Devices and Supplies
Benefits will not be provided for purchase, rental, or repair of the following:

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

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

C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).
D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and not appropriate for use in the home (e.g., parallel bars).

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

F. Eyeglasses or contact lenses, dental prostheses or appliances (except as otherwise provided herein for cleft lip or cleft palate or both), or hearing aids (except as otherwise provided herein for minor children).

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

H. Medical equipment/supplies of an expendable nature, except those specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.
This amendment is effective on the effective date of the Group Contract and Evidence of Coverage ("Evidence of Coverage") to which this amendment is attached.

TABLE OF CONTENTS
SECTION A - BREAST CANCER SCREENING
SECTION B - HOSPITALIZATION AND HOME VISITS FOLLOWING A MASTECTOMY
SECTION C - COVERAGE OF PROSTHETIC DEVICES

The Evidence of Coverage is amended as follows:

SECTION A - BREAST CANCER SCREENING

I. Description of Covered Services, Section 2.3, Preventive Services, Item C.3, Mammography Screening, is deleted and replaced with the following:

   a. Covered Services
      At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.
   b. Benefits for breast cancer screening are not subject to the Deductible, if any.

II. The Schedule of Benefits, Mammography, Benefit and Limitations, are deleted and replaced with the following:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>At a minimum, benefits will be provided in accordance with the latest guidelines issued by the American Cancer Society.</td>
</tr>
</tbody>
</table>

SECTION B - HOSPITALIZATION AND HOME VISITS FOLLOWING A MASTECTOMY

I. Description of Covered Services, Section 3, Inpatient Hospital Services, Section 3.2, Number of Hospital Days Covered, Item B, Inpatient Coverage Following a Mastectomy, is deleted and replaced with the following:

B. Inpatient Coverage Following a Mastectomy.
   Coverage will be provided for a minimum hospital stay of not less than forty-eight (48) hours following a Mastectomy.
In consultation with the Health Care Practitioner, the Member may elect to stay less than the minimum prescribed above when appropriate.

II. Description of Covered Services, Section 5, Home Health Care Services, Section 5.3, Number of Home Health Care Visits, Item A, Home Health Care Visits Following Mastectomy or Surgical Removal of a Testicle, is deleted and replaced with the following:

A. Surgical Removal of a Testicle. For a Member who receives less than 48 hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis, benefits will be provided for:

1. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and

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

3. Benefits for home visits following the surgical removal of a testicle are not subject to Copayment or Coinsurance. Benefits for home visits following the surgical removal of a testicle are not subject to a Deductible unless the Member's health plan is a high deductible health benefit plan for which a health savings account is eligible.

III. Description of Covered Services, Section 5, Home Health Care Services, Section 5.3, Number of Home Health Care Visits, item C is re-lettered as item D. Description of Covered Services, Section 5, Home Health Care Services, Section 5.3, Number of Home Health Care Visits, is amended to add the following:

C. Home Visits Following a Mastectomy.

1. For a Member who has a shorter hospital stay than that provided under Section 3.2B, Inpatient Coverage Following a Mastectomy, or who undergoes a Mastectomy on an outpatient basis, benefits will be provided for:

   a. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and

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

2. For a Member who remains in the hospital for at least the length of time provided in Section 3.2B, Inpatient Coverage Following a Mastectomy, coverage will be provided for a home visit of prescribed by the Member's attending physician.

3. Benefits for home visits following a Mastectomy are not subject to Copayment or Coinsurance. Benefits for home visits following a Mastectomy are not subject to a Deductible unless the Member's health plan is a high deductible health benefit plan with which a health savings account is eligible.

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

SECTION C - COVERAGE OF PROSTHETIC DEVICES

I. Description of Covered Services, Section 8, Medical Devices and Supplies, Section 8.2, Covered Services, is amended to add the following:

J. Prosthetic Leg, Arm and Eye.

   1. Coverage shall be provided for an artificial device which replaces, in whole or in part, a leg, an arm or an eye.
2. Coverage includes:
   a. Components of prosthetic devices; and
   b. Repairs to prosthetic devices.

3. Benefits for prosthetic legs, arms or eyes do not accrue to the annual benefit maximum, if any, for medical devices and supplies.

4. Benefits for prosthetic legs, arms or eyes are available to the same extent as benefits provided for office visits for medical treatment.

5. Requirements for Medical Necessity for coverage of a prosthetic leg, arm or eye will not be more restrictive than the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

6. Prior authorization is not required for benefits for prosthetic legs, arms or eyes.

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

Group Hospitalization and Medical Services, Inc.

[Signature]

Chester E. Burrell
President and Chief Executive Officer
MENTAL HEALTH AND SUBSTANCE ABUSE PARITY AMENDMENT

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

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

II. Schedule of Benefits, Section 7, Mental Health and Substance Abuse Services, Outpatient Mental Health and Substance Abuse Services, is deleted in its entirety and replaced as follows:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limitations (In and Out-of-Network Combined)</th>
<th>Benefits Subject to Deductible</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>Number of visits not limited.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>100% of the Allowed Benefit</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>Number of visits not limited.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>Benefits are available to the same extent as benefits provided for outpatient hospital facility services for treatment of other illnesses</td>
<td></td>
</tr>
<tr>
<td>Professional Services provided at an outpatient facility</td>
<td>Number of visits not limited.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>Benefits are available to the same extent as professional medical or surgical services provided at an outpatient hospital or ambulatory care facility for treatment of other illnesses</td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td>Number of visits not limited.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>100% of the Allowed Benefit</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td>Methadone Maintenance Visits</td>
<td>Number of visits not limited.</td>
<td>No</td>
<td>100% of the Allowed Benefit</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations (In and Out-of-Network Combined)</td>
<td>Benefits Subject to Deductible</td>
<td>In-Network</td>
<td>Member Pays</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>--------------------------------</td>
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</tr>
<tr>
<td>Outpatient Psychological and Neuropsychological Testing for Diagnostic Purposes</td>
<td>Number of visits not limited.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>100% of the Allowed Benefit</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td>Partial Hospitalization Facility Services</td>
<td>Number of visits not limited.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>Benefits are available to the same extent as benefits provided for outpatient hospital facility services for treatment of other illnesses.</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization Professional Services</td>
<td>Number of visits not limited.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>Benefits are available to the same extent as professional medical or surgical services provided at an outpatient hospital or ambulatory care facility for treatment of other illnesses.</td>
<td></td>
</tr>
</tbody>
</table>

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

**Group Hospitalization and Medical Services, Inc.**

![Signature]

Chester E. Burrell
President and Chief Executive Officer
The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Evidence of Coverage.

CareFirst pays only for Covered Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, Coinsurance or Copayment. Services that are not listed in the Description of Covered Services, or are listed in Exclusions and Limitations, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions and limitations in the Evidence of Coverage as well as its medical policies. When these conditions of coverage are not met or followed, payments for benefits may be denied. Certain Utilization Management Requirements will also apply. When these requirements are not met, payments may be denied or reduced.

| SECTION 1 - GENERAL PROVISIONS | DEDUCTIBLES | | | | |
|-------------------------------|-------------|---|---|---|
| IN-NETWORK DEDUCTIBLE | | OUT-OF-NETWORK DEDUCTIBLE | | |
| The Individual Deductible is $250 per Benefit Period. | The Individual Deductible is $500 per Benefit Period. |
| The Family Deductible is $500 per Benefit Period. | The Family Deductible is $1,000 per Benefit Period. |
| For purposes of determining the Deductible, any Type of Coverage that is not Individual is considered Family coverage. | For purposes of determining the Deductible, any Type of Coverage that is not Individual is considered Family coverage. |
| The following amounts apply to the In-Network Deductible: | The following amounts apply to the Out-of-Network Deductible: | |
| • 100% of the Allowed Benefit for covered In-Network services that are subject to the In-Network Deductible, as indicated in the benefit chart below. | • 100% of the Allowed Benefit for covered Out-of-Network services that are subject to the Out-of-Network Deductible, as indicated in the benefit chart below. |
| • Any amounts that have been applied to the Out-of-Network Deductible will also count toward the In-Network Deductible. | • Any amounts that have been applied to the In-Network Deductible will also count toward the Out-of-Network Deductible. |
**IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES**

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

**Family Coverage:** Each Member can satisfy his/her own Deductible by meeting the Individual Deductible. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Deductible. An individual family member may not contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible has been met, this will satisfy the Deductible for all covered family members.

The following amounts may **not** be used to satisfy the In-Network OR Out-of-Network Deductibles:

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

The benefit chart below indicates whether a Covered Service is subject to a Deductible. Unless otherwise specifically stated, all benefits are subject to the Deductible. If a Deductible applies, the chart will also indicate whether a Deductible applies to In-Network benefits, Out-of-Network benefits, or both.

**MAXIMUM COMBINED DEDUCTIBLE**

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

<table>
<thead>
<tr>
<th>IN-NETWORK LIMITS</th>
<th>OUT-OF-NETWORK LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Individual Out-of-Pocket Limit is $2,500 per Benefit Period.</td>
<td>The Individual Out-of-Pocket Limit is $5,000 per Benefit Period.</td>
</tr>
<tr>
<td>The Family Out-of-Pocket Limit is $5,000 per Benefit Period.</td>
<td>The Family Out-of-Pocket Limit is $10,000 per Benefit Period.</td>
</tr>
<tr>
<td>For purposes of determining the Out-of-Pocket Limit, any Type of Coverage that is not Individual is considered Family coverage.</td>
<td>For purposes of determining the Out-of-Pocket Limit, any Type of Coverage that is not Individual is considered Family coverage.</td>
</tr>
<tr>
<td><strong>The following amounts apply to the In-Network Out-of-Pocket Limit:</strong></td>
<td><strong>The following amounts apply to the Out-of-Network Out-of-Pocket Limit:</strong></td>
</tr>
<tr>
<td>• Coinsurance for covered In-Network Services</td>
<td>• Coinsurance for covered Out-of-Network Services</td>
</tr>
<tr>
<td>• Copayments for covered In-Network Services</td>
<td>• Copayments for covered Out-of-Network Services</td>
</tr>
<tr>
<td>• The In-Network Deductible</td>
<td>• The Out-of-Network Deductible</td>
</tr>
<tr>
<td>• The Out-of-Network Deductible</td>
<td>• The In-Network Deductible</td>
</tr>
</tbody>
</table>

When the Member has reached the In-Network Out-of-Pocket Limit, no further Coinsurance or Deductibles will be required in that Benefit Period for In-Network services.

When the Member has reached the Out-of-Network Out-of-Pocket Limit, no further Coinsurance or Deductibles will be required in that Benefit Period for Out-of-Network services.
IN-NETWORK AND OUT-OF-NETWORK OUT-OF-POCKET LIMITS

**Individual Coverage:** A Member who has Individual Coverage must satisfy the Individual Out-of-Pocket Limit.

**Family Coverage:** Each Member can satisfy his/her own Individual Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit. In addition, eligible expenses of all covered family members can be combined to satisfy the Family Out-of-Pocket Limit. An individual family member cannot contribute more than the Individual Out-of-Pocket Limit toward meeting the Family Out-of-Pocket Limit. Once the Family Out-of-Pocket Limit has been met, this will satisfy the Out-of-Pocket Limit for all family members.

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

- Coinsurance or Copayments, if any, for services covered under a rider or endorsement to the Evidence of Coverage, unless specifically provided in the rider or endorsement.
- Amounts incurred for failure to comply with the utilization management program requirements.
- The portion of any provider charges which is in excess of the Allowed Benefit.

**MAXIMUM COMBINED OUT-OF-POCKET LIMIT**

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

**LIFETIME MAXIMUM**

There is no Lifetime Maximum

**UTILIZATION MANAGEMENT NON-COMPLIANCE**

Failure or refusal to comply with Utilization Management requirements will result in a 50% reduction in benefits for services associated with the Member's care or treatment (other than Medically Necessary Ancillary Services). See Section 9 of the Description of Covered Services for services which require Utilization Management.
The Preferred Provider Plan offers two (2) levels of benefits. Members may select the benefit level at which coverage will be provided each time care is sought. Benefit levels are:

**Preferred Providers**
The level of benefits is reflected under In-Network Benefits in the Schedule of Benefits.

**Participating Providers**
The level of benefits is reflected under Out-of-Network Benefits in the Schedule of Benefits.

**Non-Participating Providers**
The level of benefits is reflected under Out-of-Network Benefits in the Schedule of Benefits. Non-Participating Providers may bill for any balance above the Allowed Benefit.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limitations (In and Out-of-Network Combined)</th>
<th>Benefits Subject to Deductible</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>CareFirst Pays</td>
<td>Member Pays</td>
</tr>
<tr>
<td>Office Visits</td>
<td>Out-of-Network benefits only</td>
<td>100% of the Allowed Benefit minus the Member Copay</td>
<td>$20 per visit</td>
<td>60% of the Allowed Benefit</td>
</tr>
<tr>
<td>Laboratory Tests and X-rays</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
<td>60% of the Allowed Benefit</td>
</tr>
<tr>
<td>Diagnostic Procedures</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
<td>60% of the Allowed Benefit</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Well Child Care</td>
<td>Newborn up to age 18</td>
<td>NO</td>
<td>100% of the Allowed Benefit minus the Member Copay</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Routine GYN Exam</td>
<td>At intervals appropriate to the Member’s age and health status, as determined by CareFirst</td>
<td>Out-of-Network benefits only</td>
<td>100% of the Allowed Benefit minus the Member Copay</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Adult Routine Physical Exam</td>
<td>Age 18 and over</td>
<td>Out-of-Network benefits only</td>
<td>100% of the Allowed Benefit minus the Member Copay</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>As described in the Description of Covered Services</td>
<td>NO</td>
<td>100% of the Allowed Benefit</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations (In and Out-of-Network Combined)</td>
<td>Benefits Subject to Deductible</td>
<td>In-Network</td>
<td>Out-of-Network</td>
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<tr>
<td></td>
<td></td>
<td>CareFirst Pays</td>
<td>Member Pays</td>
<td>CareFirst Pays</td>
</tr>
<tr>
<td>Routine Pap Smear</td>
<td>At intervals appropriate to the Member's age and health status, as determined by CareFirst</td>
<td>NO</td>
<td>100% of the Allowed Benefit</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td>Mammography</td>
<td>At a minimum, benefits will be provided as follows:</td>
<td>NO</td>
<td>100% of the Allowed Benefit</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Age 35-39: One baseline mammogram of each breast.</td>
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<tr>
<td></td>
<td>Age 40-49: One preventive mammogram of each breast every 24 months or more frequently if recommended by a physician.</td>
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<tr>
<td></td>
<td>Age 50 and above: One preventive mammogram of each breast every 12 months</td>
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</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>In accordance with the most current American Cancer Society guidelines.</td>
<td>NO</td>
<td>100% of the Allowed Benefit</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td>Diagnostic and Treatment Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Treatment</td>
<td></td>
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<tr>
<td></td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
<td>60% of the Allowed Benefit</td>
</tr>
<tr>
<td>Allergy Shots</td>
<td></td>
<td>Out-of-Network benefits only</td>
<td>100% of the Allowed Benefit minus the Member Copay</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations (In and Out-of-Network Combined)</td>
<td>Benefits Subject to Deductible</td>
<td>In-Network</td>
<td>Out-of-Network</td>
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</tr>
<tr>
<td>Rehabilitation Services</td>
<td>As described in the Description of Covered Services</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Spinal Manipulation</td>
<td>As described in the Description of Covered Services</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Habilitative Services</td>
<td>Must be authorized in advance under the utilization management program</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Therapeutic Treatment Services</td>
<td>As described in the Description of Covered Services</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Outpatient Surgical Procedures</td>
<td>As described in the Description of Covered Services</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Diagnostic and Treatment Services</td>
<td>As described in the Description of Covered Services</td>
<td>Benefits are available to the same extent as benefits provided for outpatient medical care, surgical care and diagnostic services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity and Related Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Benefits</td>
<td>Benefits are available to all Members</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Extended Benefits</td>
<td>Benefits are available to all Members.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations</td>
<td>Benefits Subject to Deductible</td>
<td>In-Network</td>
<td>Out-of-Network</td>
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</tr>
<tr>
<td>Artifical Insemination</td>
<td>Must be authorized in advance under the utilization management program Preferred and Participating Providers will handle these requirements In-Network</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>In-Vitro Fertilization</td>
<td>Must be authorized in advance under the utilization management program Preferred and Participating Providers will handle these requirements In-Network Limited to 3 attempts per live birth and a lifetime maximum benefit of $100,000</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
</tbody>
</table>

### Outpatient Hospital and Ambulatory Care Facility and Professional Services

<table>
<thead>
<tr>
<th>Outpatient Hospital Facility Services</th>
<th>Routine/Screening Colonoscopy is not subject to the deductible</th>
<th>In-Network and Out-of-Network benefits</th>
<th>80% of the Allowed Benefit</th>
<th>20% of the Allowed Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care Facility Services</td>
<td>Routine/Screening Colonoscopy is not subject to the deductible</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Professional Medical or Surgical Services provided at an outpatient hospital or ambulatory care facility</td>
<td>Routine/Screening Colonoscopy is not subject to the deductible</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations (In and Out-of-Network Combined)</td>
<td>Benefits Subject to Deductible</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
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</tr>
<tr>
<td>Anesthesia Services</td>
<td>General anesthesia for dental care must be authorized in advance under the utilization management program. Preferred and Participating Providers will handle these requirements In-Network. Benefits for anesthesia services other than for dental care apply when provided in connection with a covered procedure.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Must be authorized in advance under the utilization management program. Preferred and Participating Providers will handle these requirements In-Network. Limited to 90 days per Benefit Period.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>Limited to Emergency Services</td>
<td>In-Network Deductible applies</td>
<td>80% of the Allowed Benefit minus the Member Copay</td>
<td>20% of the Allowed Benefit and $50 per visit</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>No annual dollar limit</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Ambulance Service when the Member is Outside the United States</td>
<td>Limited to transportation to the nearest medically appropriate facility when the Member is outside the United States. No annual dollar limit.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations (In and Out-of-Network Combined)</td>
<td>Benefits Subject to Deductible</td>
<td>In-Network</td>
<td>Out-of-Network</td>
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<tr>
<td><strong>SECTION 3 - INPATIENT HOSPITAL SERVICES</strong></td>
<td></td>
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</tr>
<tr>
<td>Inpatient Hospital Facility Services (medical or surgical condition, including maternity)</td>
<td>Must be authorized in advance under the utilization management program Preferred and Participating Providers will handle these requirements In-Network No prior authorization required for routine maternity admissions</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CareFirst Pays</td>
<td>Member Pays</td>
</tr>
<tr>
<td>Physician and Medical/Surgical Services (including services provided by Exempt Providers)</td>
<td>Except for Ancillary Services, covered only if hospital day qualifies for coverage</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Services and Supplies Ordinarily Furnished by a Hospital to its Patients</td>
<td>As described in the Description of Covered Services Except for Ancillary Services, covered only if hospital day qualifies for coverage</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td><strong>SECTION 4 - SKILLED NURSING FACILITY SERVICES</strong></td>
<td></td>
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</tr>
<tr>
<td>Skilled Nursing Facility Services</td>
<td>Must be authorized in advance under the utilization management program Preferred and Participating Providers will handle these requirements In-Network Limited to 60 days per Benefit Period</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CareFirst Pays</td>
<td>Member Pays</td>
</tr>
<tr>
<td>Physician and Medical/Surgical Services (including services provided by Exempt Providers)</td>
<td>Except for Ancillary Services, covered only if Skilled Nursing Facility day qualifies for coverage</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CareFirst Pays</td>
<td>Member Pays</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations (In and Out-of-Network Combined)</td>
<td>Benefits Subject to Deductible</td>
<td>In-Network CareFirst Pays</td>
<td>In-Network Member Pays</td>
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<tr>
<td><strong>SECTION 5 - HOME HEALTH CARE SERVICES</strong></td>
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</tr>
<tr>
<td>Home Health Services</td>
<td>Must be authorized in advance under the utilization management program. Preferred and Participating Providers will handle these requirements In-Network. Limited to 40 visits, up to four hours per visit per Benefit Period. Benefits for Postpartum Home visits will not be applied to this limitation.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Home Health Care Visits Following Mastectomy or Surgical Removal of a Testicle</td>
<td>As described in the Description of Covered Services. The Benefit Period visit limitation does not apply.</td>
<td>NO</td>
<td>100% of the Allowed Benefit</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td>Postpartum Home Visits</td>
<td>As described in the Description of Covered Services.</td>
<td>NO</td>
<td>100% of the Allowed Benefit</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td><strong>SECTION 6 - HOSPICE CARE SERVICES</strong></td>
<td>Hospice Care services are limited to a maximum 180 day Hospice Eligibility Period.</td>
<td></td>
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</tr>
<tr>
<td>Inpatient Care</td>
<td>Must be authorized in advance under the utilization management program. Preferred and Participating Providers will handle these requirements In-Network. Limited to 30 days per Member.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations (In and Out-of-Network Combined)</td>
<td>Benefits Subject to Deductible</td>
<td>In-Network</td>
<td>Out-of-Network</td>
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</tr>
<tr>
<td>Outpatient care</td>
<td>Must be authorized in advance under the utilization management program Preferred and Participating Providers will handle these requirements In-Network Unlimited visits during Hospice Eligibility Period</td>
<td>In-Network and Out-of-Network benefits</td>
<td>CareFirst Pays: 80% of the Allowed Benefit Member Pays: 20% of the Allowed Benefit</td>
<td>CareFirst Pays: 60% of the Allowed Benefit Member Pays: 40% of the Allowed Benefit</td>
</tr>
<tr>
<td>Respite Care</td>
<td>Must be authorized in advance under the utilization management program Preferred and Participating Providers will handle these requirements In-Network Limited to 14 days annually.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>CareFirst Pays: 80% of the Allowed Benefit Member Pays: 20% of the Allowed Benefit</td>
<td>CareFirst Pays: 60% of the Allowed Benefit Member Pays: 40% of the Allowed Benefit</td>
</tr>
<tr>
<td>Bereavement and Family Counseling</td>
<td>Must be authorized in advance under the utilization management program Preferred and Participating Providers will handle these requirements In-Network Bereavement Counseling is limited to the 6-month period following patient's death or 15 visits whichever occurs first Bereavement Counseling is limited to the 180 day Hospice Eligibility Period</td>
<td>In-Network and Out-of-Network benefits</td>
<td>CareFirst Pays: 80% of the Allowed Benefit Member Pays: 20% of the Allowed Benefit</td>
<td>CareFirst Pays: 60% of the Allowed Benefit Member Pays: 40% of the Allowed Benefit</td>
</tr>
</tbody>
</table>
### SECTION 7 - MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

#### Outpatient Mental Health and Substance Abuse Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limitations (In and Out-of-Network Combined)</th>
<th>Benefits Subject to Deductible</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits and Outpatient Facility Services</strong></td>
<td></td>
<td></td>
<td>Per Benefit Period: Visits 1-5: 80% of the Allowed Benefit</td>
<td>Per Benefit Period: Visits 1-5: 20% of the Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Visits 6-30: 65% of the Allowed Benefit</td>
<td>Visits 6-30: 35% of the Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Visits in excess of 30: 50% of the Allowed Benefit</td>
<td>Visits in excess of 30: 50% of the Allowed Benefit</td>
</tr>
<tr>
<td><strong>Medication Management Office Visits</strong></td>
<td></td>
<td></td>
<td>In-Network and Out-of-Network benefits</td>
<td>In-Network and Out-of-Network benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>100% of the Allowed Benefit minus the Member Copay</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Methadone Maintenance Visits</strong></td>
<td>No prior authorization required.</td>
<td>NO</td>
<td>100% of Allowed Benefit minus the Member Copay</td>
<td>$20 per visit</td>
</tr>
<tr>
<td></td>
<td>The Member payment will not be greater than 50% of its daily cost</td>
<td></td>
<td>Covered at the In-Network Level (does not require the use of a Preferred Provider)</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient neuro-psychological testing for diagnostic purposes</strong></td>
<td></td>
<td></td>
<td>In-Network and Out-of-Network benefits</td>
<td>In-Network and Out-of-Network benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>80% of the Allowed Benefit</td>
<td>80% of the Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>20% of the Allowed Benefit</td>
<td>20% of the Allowed Benefit</td>
</tr>
<tr>
<td><strong>Partial Hospitalization</strong></td>
<td>Mental Health Management Program must be contacted for prior authorization</td>
<td>Out-of-Network benefits only</td>
<td>100% of the Allowed Benefit minus the Member Copay</td>
<td>$20 per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$20 per visit</td>
<td>60% of the Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>40% of the Allowed Benefit</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations (In and Out-of-Network Combined)</td>
<td>Benefits Subject to Deductible</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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</tr>
<tr>
<td>Inpatient Mental Health and Substance Abuse Hospitalization</td>
<td><strong>Inpatient Facility Services</strong>&lt;br&gt;Must be authorized in advance under the utilization management program&lt;br&gt;Preferred and Participating Providers will handle these requirements In-Network</td>
<td><strong>In-Network</strong>&lt;br&gt;and Out-of-Network benefits</td>
<td>CareFirst Pays</td>
<td>Member Pays</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network</strong> benefits</td>
<td>Benefits are available to the same extent as benefits provided for other illnesses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Crisis Services</td>
<td><strong>Facility Services</strong>&lt;br&gt;As described in the Description of Covered Services&lt;br&gt;Except for Ancillary Services, covered only if hospital day qualifies for coverage</td>
<td><strong>In-Network</strong>&lt;br&gt;and Out-of-Network benefits</td>
<td>Benefits are available to the same extent as benefits provided for other illnesses</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Professional Services</strong>&lt;br&gt;As described in the Description of Covered Services.&lt;br&gt;Except for Ancillary Services, covered only if hospital day qualifies for coverage</td>
<td><strong>In-Network</strong>&lt;br&gt;and Out-of-Network benefits</td>
<td>Benefits are available to the same extent as benefits provided for other illnesses</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION 8 - MEDICAL DEVICES AND SUPPLIES**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limitations</th>
<th>In-Network and Out-of-Network benefits</th>
<th>Limitations</th>
<th>In-Network and Out-of-Network benefits</th>
<th>80% of the Allowed Benefit</th>
<th>20% of the Allowed Benefit</th>
<th>60% of the Allowed Benefit</th>
<th>40% of the Allowed Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Devices and Supplies</td>
<td>No Benefit Period maximum</td>
<td><strong>In-Network</strong> and Out-of-Network benefits</td>
<td><strong>Limited to maximum payment of $350 per Benefit Period</strong>&lt;br&gt;Benefit is not subject to the Benefit Period maximum, if any, for Medical Devices and Supplies</td>
<td>NO</td>
<td>100% of the Allowed Benefit up to the maximum payment</td>
<td>No Copay or Coinsurance</td>
<td>Member is responsible for amounts above the maximum payment</td>
<td>100% of the Allowed Benefit up to the maximum payment</td>
</tr>
<tr>
<td>Hair Prosthesis</td>
<td>Limited to maximum payment of $350 per Benefit Period</td>
<td><strong>NO</strong></td>
<td><strong>Limited to maximum payment</strong></td>
<td>100% of the Allowed Benefit up to the maximum payment</td>
<td>No Copay or Coinsurance</td>
<td>Member is responsible for amounts above the maximum payment</td>
<td>100% of the Allowed Benefit up to the maximum payment</td>
<td>No Copay or Coinsurance</td>
</tr>
<tr>
<td>Benefit</td>
<td>Limitations (In and Out-of-Network Combined)</td>
<td>Benefits Subject to Deductible</td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td></td>
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<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
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<td>----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Hearing Aids for Minor Children</td>
<td>Limited to a maximum of $1,400 every 36 months for one hearing aid for each hearing impaired ear. Limited to Members who are minor children. Benefit is not subject to the Benefit Period maximum, if any, for Medical Devices and Supplies.</td>
<td>NO</td>
<td>100% of the Allowed Benefit up to the maximum payment</td>
<td>No Copay or Coinsurance Member is responsible for amounts above the maximum payment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Outpatient Services for Hearing Aid</td>
<td>Limited to Members who are minor children. Benefit is not subject to the Benefit Period maximum, if any, for Medical Devices and Supplies.</td>
<td>Out-of-Network benefits only</td>
<td>$20 per visit</td>
<td>60% of the Allowed Benefit</td>
<td>40% of the Allowed Benefit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Foods and Low Protein Modified Food Products</td>
<td>Benefit is not subject to the Benefit Period maximum, if any, for Medical Devices and Supplies.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit, 20% of the Allowed Benefit</td>
<td>60% of the Allowed Benefit</td>
<td>40% of the Allowed Benefit</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Amino Acid-Based Elemental Formulas</td>
<td>Benefit is not subject to the Benefit Period maximum, if any, for Medical Devices and Supplies.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit, 20% of the Allowed Benefit</td>
<td>60% of the Allowed Benefit</td>
<td>40% of the Allowed Benefit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Equipment and Supplies</td>
<td>Benefit is not subject to the Benefit Period maximum, if any, for Medical Devices and Supplies.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit, 20% of the Allowed Benefit</td>
<td>60% of the Allowed Benefit</td>
<td>40% of the Allowed Benefit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Prosthesis and Mastectomy Bras</td>
<td>Benefit is not subject to the Benefit Period maximum, if any, for Medical Devices and Supplies.</td>
<td>In-Network and Out-of-Network benefits</td>
<td>80% of the Allowed Benefit, 20% of the Allowed Benefit</td>
<td>60% of the Allowed Benefit</td>
<td>40% of the Allowed Benefit</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Group Hospitalization and Medical Services, Inc.**

[Signature]

Chester E. Burrell  
President and Chief Executive Officer
This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached. Notwithstanding any provision to the contrary, the Evidence of Coverage is amended as follows:

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

BlueCard, and BlueCard PPO, if applicable, enable Members to access on-site Blue Cross and/or Blue Shield Licensees' ("Host Blues") networks of contracted providers for services rendered outside the area CareFirst serves (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 geographic area CareFirst serves, 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").

When a Member obtains health care services through BlueCard outside the geographic area CareFirst serves, the amount paid for covered services is calculated on the lower of:

- The billed charges for the covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield ("Host Blue") passes on to CareFirst.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with the health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount the Member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. When Members receive covered services in these states, the Members' liability for covered services will be calculated using these states' statutory methods. However, when this payment methodology results in a conflict of statutes or regulations between two states, CareFirst will comply with the statutes of the State of Maryland.
**Utilization Management Requirements and BlueCard**

The Utilization Management Requirements of the Evidence of Coverage, 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 out-of-area care CareFirst deems not Medically Necessary; and/or not covered under the Evidence of Coverage.

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 Evidence of Coverage. Such variances may result from state laws that differ from those in Maryland 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 geographic area CareFirst serves should call 1-800-810-BLUE (2583) for that Host Blue's utilization management requirements/provider network rules prior to receiving services.

**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.

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

**Group Hospitalization and Medical Services, Inc.**

![Signature]

Chester E. Burrell  
President and Chief Executive Officer
Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan
An independent licensee of the BlueCross and BlueShield Association

DEPENDENT ELIGIBILITY AMENDMENT

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

Sections 2.4 and 2.5 of the Out-of-Network Evidence of Coverage are deleted and replaced with the following:

2.4 Eligibility of Dependent Children. If the Group has elected to include coverage for Dependent Children of the Subscriber or a Subscriber's covered Spouse under this Out-of-Network Evidence of Coverage, then a Subscriber may enroll a Dependent Child. A Dependent Child means an individual who:

A. Is:

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

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

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

B. Has not provided over one-half of his or her own support for the previous calendar year;

C. Is unmarried; and

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

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

F. Is a child who is the subject of a Medical Child Support Order ("MCSO") or a Qualified Medical Support Order ("QMSO") that creates or recognizes the right of the child to receive benefits under the health insurance coverage of the Subscriber or the Subscriber's covered Spouse.
G. A child whose relationship to the Subscriber is not listed above, including, a foster child or a child whose only relationship is one of legal guardianship (except as provided above), is not eligible to enroll and is not covered under this Out-of-Network Evidence of Coverage, even though the child may live with the Subscriber and be dependent upon him or her for support.

2.5 Limiting Age for Covered Dependent Children

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

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

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

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

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

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

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

This amendment is issued to be attached to the Out-of-Network Evidence of Coverage. This amendment does not change the terms and conditions of the Out-of-Network Evidence of Coverage unless specifically stated herein.

Group Hospitalization and Medical Services, Inc.

[Signature]

Chester E. Burrell
President and Chief Executive Officer
Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan
An independent licensee of the Blue Cross and Blue Shield Association

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE LIFE AND HEALTH INSURANCE GUARANTY CORPORATION SUBTITLE

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Maryland Life and Health Insurance Guaranty Corporation. The purpose of this is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty corporation will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty corporation is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting companies that are well managed and financially stable.

The Maryland Life and Health Insurance Guaranty Corporation may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Maryland. You should not rely on coverage by the Maryland Life and Health Insurance Guaranty Corporation in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. Insurance companies or their insurance producers are required by law to give or send you this notice. However, insurance companies and their insurance producers are prohibited by law from using the existence of the guaranty corporation to induce you to purchase any kind of insurance policy.

The Maryland Life and Health Insurance Guaranty Corporation
9199 Reisterstown Road P.O. Box 671----Suite 216C
Owings Mills, Maryland 21117
410-998-3907

The state law that provides for this safety-net coverage is called the Life and Health Insurance Guaranty Corporation. The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

Following is a brief summary of this law's coverage, exclusions, and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the law or the rights or obligations of the guaranty corporation.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Corporation if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state.
EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this corporation if: they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured whom live outside that state); the insurer was not authorized to do business in this state; their policy was issued by a Health Maintenance Organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessment, or by an insurance exchange.

The corporation also does not provide coverage for: any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; any policy of reinsurance, unless assumption certificates have been issued; interest rate yields that exceed an average rate; any portion of a policy or contract to the extent that it provides dividends; credits given in connection with the administration of a policy by a group contract holder; employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); unallocated annuity contracts (which give rights to group contract holders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The statute also limits the amount that the corporation is obligated to pay. The corporation cannot pay more than the amount the insurance company would owe under a policy or contract. Also, with respect to any one life, regardless of the number of policies or contracts with the member insurer, the corporation will pay a maximum of: $300,000 in life insurance death benefits, but will not pay more than $100,000 in life insurance cash surrender values; $300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values; and $100,000 in the present value of annuity benefits, including any net cash surrender and net cash withdrawal values. These amounts are the maximum, no matter how many policies and contracts the insured has with the member company.
COMPENSATION AND PREMIUM DISCLOSURE STATEMENT

Our compensation to providers who offer health care services and behavioral health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your physician, please call our Member Services Department at the number listed on your identification card, or write to:

Group Hospitalization and Medical Services, Inc.
doing business as CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC  20065
Attention: Member Services

A. METHODS OF PAYING PHYSICIANS

This table shows definitions of how insurance carriers may pay physicians (or other providers) for your health care services with a simple example of how each payment mechanism works.

<table>
<thead>
<tr>
<th>Terms</th>
<th>The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>A physician (or other provider) is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services. Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing pre-natal care to Mrs. Smith, who is a member of the HMO, Dr. Jones’ salary is unchanged. Although Mrs. Smith’s baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have an effect upon Dr. Jones' salary.</td>
</tr>
<tr>
<td>Capitation</td>
<td>A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires. Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.</td>
</tr>
</tbody>
</table>
This table shows definitions of how insurance carriers may pay physicians (or other providers) for your health care services with a simple example of how each payment mechanism works.

<table>
<thead>
<tr>
<th>Payment Mechanism</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
</table>
| Fee-for-Service         | A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder.  

Dr. Jones’ contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill. |
| Discounted Fee-for-Service | Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician (or other provider), who usually gets an increased volume of patients.  

Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones’ usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or HMO. |
| Bonus                   | A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.  

An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment. |
| Case Rate               | The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care.  

This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith. |
B. PERCENTAGE OF PROVIDER PAYMENT METHODS

For its Indemnity and Preferred Provider Organization (PPO) products, CareFirst BlueCross BlueShield contracts directly with physicians. All physicians are reimbursed on a discounted fee-for-service basis.

C. DISTRIBUTION OF PREMIUM DOLLARS

The bar graph below illustrates the proportion of every $100 in premium used by CareFirst BlueCross BlueShield to pay providers (or other providers) for medical care expenses, and the proportion used to pay for plan administration.

These numbers represent an average for all indemnity accounts based on our annual statement. The ratio of direct medical care expenses to plan administration will vary by account.
VISION CARE RIDER

This rider contains certain terms that have a specific meaning as to Vision Care benefits. These terms are capitalized and are defined in Section A. below, or in the Contract or Agreement ("evidence of coverage") to which it is attached.

This rider is issued by CareFirst to be attached to and become a part of the evidence of coverage. A Member's effective date of coverage under this rider and termination date of coverage under this rider are the same as the Member's effective date and termination date under the evidence of coverage.

This rider contains specific exclusions and limitations applicable to Vision Care benefits that are in addition to the exclusions contained in the evidence of coverage to which this rider is attached.

TABLE OF CONTENTS

SECTION A - GENERAL PROVISIONS
SECTION B - DEFINITIONS
SECTION C - WHAT IS COVERED
SECTION D - HOW IT IS COVERED
SECTION E - SCHEDULE OF BENEFITS
SECTION F - EXCLUSIONS

A. GENERAL PROVISIONS

1. Notwithstanding any provision in the evidence of coverage, benefits for routine Vision Care are limited to the services listed in this rider. Benefits under this rider are administered by CareFirst's Vision Care Designee.

2. The Member's responsibility for covered Vision Care is stated in Section D, How It Is Covered. In addition, the Member will be responsible for services, supplies or care which are not covered. Services, supplies or care that are not listed as Vision Care benefits or are listed as exclusion are not covered services under this rider.

3. Timely Filing.

   All claims submitted to the Vision Care Designee must be submitted within 12 months after the date the covered service is received. The Vision Care Designee will only consider claims beyond the 12-month filing period if the Member became legally incapacitated prior to the end of the filing period.

B. DEFINITIONS. In addition to the definitions contained in the evidence of coverage to which this rider is attached, the underlined terms, below, when capitalized, have the following meanings:


Allowed Benefit means:

1. For a Contracting Provider, the Allowed Benefit for a covered service is the lesser of:
   a. The actual charge, which, in some cases, will be a rate set by a regulatory agency; or
   b. The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date that the service is rendered.

   The benefit payment is made directly to a Contracting Provider. When a Member receives a vision examination from a Contracting Provider, the benefit payment is accepted as payment in full, except for any applicable co-payment. The Contracting Provider may collect any applicable co-payment.

2. For a Non-Contracting Provider, the Allowed Benefit for a covered service will be determined in the same manner as the Allowed Benefit to a Contracting Provider.

   Benefits may be paid to the Member or to the Non-Contracting Provider at the discretion of the Vision Care Designee. The Member is responsible for the cost difference between the Vision Care Designee's payment and the Non-Contracting Provider's actual charge. The Non-Contracting provider may bill the Member directly.

Benefit Period means the period of time during which covered Vision Care benefits are eligible for payment. The Benefit Period is on a calendar year basis.

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

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

Vision Care means those services for which benefits are provided under this rider.

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

C. WHAT IS COVERED

1. Vision Examination
   a. One vision examination per Benefit Period. A vision examination may include, but is not limited to:
      i. Case history;
      ii. External examination of the eye and adnexa;
      iii. Ophthalmoscopic examination;
      iv. Determination of refractive status;
v. Binocular balancing test;
vi. Tonometry test for glaucoma;
vii. Gross visual field testing;
viii. Color vision testing;
ix. Summary finding; and,
x. Recommendation, including prescription of corrective lenses.

D. HOW IT IS COVERED

1. When the Member receives a vision examination from a Contracting Provider, the benefit payment is accepted as payment in full, except for any applicable co-payment stated in the Schedule of Benefits below.

2. When the Member receives Vision Care from a Non-Contracting Provider, the Member is responsible for the cost difference between the Vision Care Designee's payment stated in the Schedule of Benefits below and the Non-Contracting Provider's actual charge. The Vision Care Designee payment will be the lesser of the Non-Contracting Provider's actual charge and the Out-of-Network payment amount listed in the attached Schedule of Benefits.

E. SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Vision Care Designee Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vision Care Designee Payment</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>Vision Examination</td>
<td>100% of the Allowed Benefit after a Member co-payment of $10 when Member receives covered services from a Contracting Provider.</td>
</tr>
<tr>
<td></td>
<td>Out-Of-Network</td>
</tr>
<tr>
<td></td>
<td>$33</td>
</tr>
</tbody>
</table>

F. EXCLUSIONS

The following services are excluded from coverage:

1. Diagnostic services, except as listed in WHAT IS COVERED.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the evidence of coverage to which this rider is attached.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the evidence of coverage or a rider or endorsement purchased by your Group and attached to the evidence of coverage to which this rider is attached.
4. Services or supplies not specifically approved by the Vision Care Designee where required in WHAT IS COVERED.
5. Orthoptics, vision training and low vision aids.
6. Glasses, sunglasses or contact lenses.
7. Vision Care services for cosmetic use.
This rider is issued to be attached to the evidence of coverage.

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer
PRESCRIPTION DRUG BENEFITS RIDER

This rider is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. A Member's effective date of coverage under this rider and termination date of coverage under this rider are the same as the Member's effective date and termination date under the Evidence of Coverage.

This rider contains specific exclusions and limitations applicable to Prescription Drug benefits that are in addition to the exclusions contained in the Evidence of Coverage to which this rider is attached.

TABLE OF CONTENTS
SECTION A - DEFINITIONS
SECTION B - PRESCRIPTION DRUG BENEFITS
SECTION C - MAIL ORDER PROGRAM
SECTION D - COPAYMENTS AND COINSURANCE
SECTION E - EXCLUSIONS

A. DEFINITIONS. In addition to the definitions contained in the Evidence of Coverage to which this rider is attached, the underlined terms, below, when capitalized, have the following meanings:

Allowed Benefit, as used in this rider, means:
1. For a Contracting Provider, the Allowed Benefit for a covered service is the lesser of:
   a. the actual charge; or
   b. the amount CareFirst allows for the covered service or supply 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 any applicable Deductible, or Copayment or Coinsurance as stated in this rider. The Member is responsible for any applicable Deductible, or Copayment or Coinsurance and the Contracting Provider may bill the Member directly for such amounts.

2. For a non-Contracting Provider, the Allowed Benefit for a covered service will be determined in the same manner as the Allowed Benefit for a Contracting Provider.

   The Member is responsible for the difference between the Allowed Benefit and the non-Contracting Provider's total charge. The non-Contracting provider may bill the Member directly.

Benefit Period, as used in this rider, means the period of time during which covered Prescription Drug benefits are eligible for payment. The Benefit Period is on a calendar year basis.

Brand Name Drug means a Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and that may be used and protected by a trademark.
Coinsurance, as used in this rider, means the percentage of the Allowed Benefit allocated between CareFirst and the Member, whereby CareFirst and the Member share in the payment for covered Prescription Drugs.

Contracting Provider, as used in this rider, means the separate independent Pharmacist or Pharmacy that has contracted with CareFirst or its designee to provide Prescription Drugs in accordance with the terms of this rider.

Copayment (Copay), as used in this rider, means a fixed dollar amount that a Member must pay for certain covered Prescription Drugs.

Diabetic Supplies means all Medically Necessary and appropriate supplies prescribed by a health care provider for the treatment of diabetes.

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

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

Over-the-Counter, as used in this rider, means medications and supplies that may be purchased without a prescription.

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

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

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

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

Prescription Drug means a drug, biological or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;" and, drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature. For purposes of this rider, Prescription Drug also includes Diabetic Supplies.

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

B. PRESCRIPTION DRUG BENEFITS

1. Benefits will be provided for a Prescription Drug dispensed by a Pharmacist for self-administered-use on an outpatient basis for the treatment of a condition for which benefits are provided under the terms of the Evidence of Coverage or an attached rider.

2. CareFirst or its designee reserves the right to substitute a Generic Drug for any Brand Name Drug unless otherwise indicated on the prescription order.
3. Members may obtain up to a thirty-four (34) day supply of a non-Maintenance Drug, and up to a ninety (90) day supply of a Maintenance Drug, from a Pharmacist or through the mail order program described in Section C., Mail Order Program, below.

4. A Member may select a Prescription Drug that is not included on the Preferred Drug List. In addition to the non-Preferred Brand Name Drug Copayment or Coinsurance, an additional penalty will apply if the non-Preferred Brand Name Drug is a Brand Drug that has a Generic equivalent. If a Member selects a non-Preferred Brand Name Drug when a Generic Drug is available, the Member will pay the non-Preferred Brand Name Drug Copayment or Coinsurance plus the difference between the price of the non-Preferred Brand Name Drug and the Generic Drug up to the cost of the prescription.

If a drug on the Preferred Drug List is determined to be inappropriate therapy for the medical condition of the Member, the Member will be allowed to obtain a specific, Medically Necessary non-Preferred Drug List Prescription Drug for the non-Preferred Brand Name Drug Copayment or Coinsurance.

5. Providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Prescription Drug on the Prior Authorization List. A copy of the Prior Authorization List is available to the Member or Provider upon request.

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

**Timely Filing**: All claims submitted to CareFirst or its designee pursuant to this provision, must be submitted within twelve (12) months after the date the Prescription Drug was dispensed. CareFirst or its designee will only consider claims beyond the twelve (12) -month filing period if the Member became legally incapacitated prior to the end of the filing period.

7. Benefits include:
   a. Any contraceptive drug or device that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. Coverage for procedures for insertion or removal and any Medically Necessary examinations associated with the use of such contraceptive drugs or devices shall be provided under the medical benefits outlined in the Evidence of Coverage to which this rider is attached.
   
   b. Growth hormones.
   
   c. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber. Coverage is not provided for a drug that may be obtained over-the-counter without a prescription.

   **Nicotine Replacement Therapy**: Nicotine Replacement Therapy means a product that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber. Nicotine Replacement Therapy does not include any Over-the-Counter product that may be obtained without a prescription. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.
   
   d. Injectable medications that are self-administered and the prescribed syringes.
e. Standard covered items such as insulin, glucagon and anaphylaxis kits.
f. Fluoride products.
g. Diabetic Supplies. The Benefit Period Maximum does not apply to Diabetic Supplies.
h. Infertility drugs and agents.

C. MAIL ORDER PROGRAM
All Members have the option of ordering Prescription Drugs via mail order. Members ordering Prescription Drugs through the mail order program will be entitled to a thirty-four (34) day supply for non-Maintenance Drugs and a ninety (90) day supply for Maintenance Drugs. Members will be responsible for the Copayment or Coinsurance as outlined in Section D., Copayments and Coinsurance, below.

D. COPAYMENTS AND COINSURANCE
1. The Member must pay the Copayment or Coinsurance at the time that a prescription is filled by the Pharmacist.

2. For Prescription Drugs purchased in a Pharmacy or purchased through the mail order program, there is one Copayment due for each thirty-four (34) day supply. For Maintenance Drugs, a Member may receive up to a ninety (90) day supply provided the Member pays one Copayment for the first thirty-four (34) day supply and a second Copayment for a supply of thirty-five (35) days or more.

3. The Copayment is:
   a. Generic Drug: $15 per prescription or refill.
   b. Preferred Brand Name Drug: $35 per prescription or refill.
   c. Non-Preferred Brand Name Drug: $60 per prescription or refill.

4. For each thirty-four (34) day supply of covered injectable non-Maintenance Drugs that are self-administered, except for insulin, the Member will be required to pay 50% of Allowed Benefit up to a Member maximum Copayment of $100 per covered injectable medication. For up to a ninety (90) day supply of self-administered, injectable Maintenance Drugs, except for insulin, the Member will be required to pay 50% of the Allowed Benefit up to a Member maximum payment of $200.

5. If the cost of the Prescription Drug is less than the Copayment, then the cost of the Prescription Drug will be payable by the Member at the time the prescription is filled.

6. Diabetic Supplies are not subject to any Copayments or Coinsurance.

E. EXCLUSIONS
Benefits will not be provided under this rider for:
1. Any devices, appliances, supplies, and equipment except as otherwise provided in Section B, above.

2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.

3. Prescription Drugs for cosmetic use.

4. Prescription Drugs administered by a physician or dispensed in a physician's office.

5. Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst.
6. Drugs or medications lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a prescription (Over-the-Counter medications).

7. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
   a. prenatal vitamins.
   b. fluoride and fluoride containing vitamins.
   c. single entity vitamins, such as Rocaltrol and DHT.

8. Any portion of a Prescription Drug that exceeds:
   a. a thirty-four (34) day supply for non-Maintenance Drugs; or,
   b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst.

9. Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility’s premises for a Member who is not a patient in the health care facility.


12. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

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

Group Hospitalization and Medical Services, Inc.

Chester E. Burrell
President and Chief Executive Officer
DOMESTIC PARTNER ELIGIBILITY RIDER

This rider contains certain terms that have a specific meaning as to the eligibility of a Domestic Partner and the Dependent Children of a Domestic Partner. These terms are capitalized and are defined in Section A, in the subsequent sections, or in the Group Contract or Certificate of Coverage to which this rider is attached.

This rider is issued by CareFirst to be attached to and become part of the Certificate of Coverage. A Member's effective date of coverage under this rider and termination date of coverage under this rider are the same as the Member's effective date and termination date under the Certificate of Coverage.

This rider contains specific requirements applicable to Domestic Partner eligibility and the eligibility of a Dependent Child of a Domestic Partner that are in addition to the eligibility requirements of the Subscriber and other Dependents contained in the Certificate of Coverage to which this rider is attached.

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SECTION A - DEFINITIONS
SECTION B - ELIGIBILITY AND ENROLLMENT
SECTION C - CONTINUATION OF COVERAGE
SECTION D - CONVERSION PRIVILEGE

SECTION A - DEFINITIONS

The definition of Dependent in the Certificate of Coverage is deleted and replaced with the following:

Dependent means a Member who is covered under this Certificate of Coverage as the eligible spouse, eligible Dependent Child, eligible Domestic Partner of a Subscriber, or eligible Dependent Child of a Domestic Partner.

The Certificate of Coverage is amended to add the following definitions:

Domestic Partner means a person who cohabitates/resides with the Subscriber in a Domestic Partnership.

Domestic Partnership means a relationship between the Subscriber and Domestic Partner that meets the criteria as stated in Section B.1.b.

SECTION B - ELIGIBILITY AND ENROLLMENT

The Certificate of Coverage is amended to include the following:

1. Eligibility of Subscriber's Domestic Partner. The subscriber may enroll his/her eligible Domestic Partner. An eligible Domestic Partner will be eligible for coverage to the same extent as a Subscriber's spouse.
a. Requirements for Coverage. To be eligible for coverage as the Domestic Partner of a Subscriber, the following conditions must be met:

i. The individual must be eligible for coverage as a Domestic Partner as defined in Section B.1.b.

ii. The Subscriber must elect coverage for his/her Domestic Partner.

iii. Premium payments must be made as required under this Certificate of Coverage.

b. To be covered as a Dependent, a Domestic Partner must meet the eligibility requirements described herein. The Subscriber cannot cover or continue to cover his/her Domestic Partner if the Domestic Partnership does not meet the following requirements:

i. The Subscriber and the Domestic Partner are the same sex or opposite sex and both are at least eighteen (18) years of age and have the legal capacity to enter into a contract;

ii. The Subscriber and the Domestic Partner are not parties to a legally recognized marriage and are not in a civil union or domestic partnership with anyone else;

iii. The Subscriber and Domestic Partner are not related to the other by blood or marriage within four (4) degrees of consanguinity under civil law rule;

iv. The Subscriber and Domestic Partner share a common primary residence. The Subscriber must submit one (1) of the following documents as proof of a shared common primary residence:

   a) Common ownership of the primary residence via joint deed or mortgage agreement;

   b) Common leasehold interest in the primary residence;

   c) Driver's license or State-issued identification listing a common address; or,

   d) Utility or other household bill with both the name of the Subscriber and the Domestic Partner appearing.

v. The Subscriber and Domestic Partner are Financially Interdependent, as defined in this rider, and submit documentary evidence of their committed relationship of financial interdependence, existing for at least six (6) consecutive months prior to application.

Financially Interdependent means the Subscriber and Domestic Partner can establish that they are in a committed relationship of financial interdependence in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely. Financial Interdependence can be established by submitting documentation from any one (1) of the following criteria:

a) Joint bank account or credit account;

b) Designation of one partner as the other's primary beneficiary with respect to life insurance or retirement benefits;

c) Designation of one partner as the primary beneficiary under the other partner's will;
d) Mutual assignments of valid durable powers of attorney under §13-601 of the Estates and Trusts Article of the Annotated Code of Maryland, or the applicable laws of any state or the District of Columbia;

e) Mutual valid written advanced directives under §5-601 of the Health-General Article of the Annotated Code of Maryland, or the applicable laws of any state or the District of Columbia, approving the other partner as health care agent;

f) Joint ownership or holding of investments; or

g) Joint ownership or lease of a motor vehicle.

2. **Eligibility of a Child of a Subscriber's Domestic Partner.** The child of Subscriber's Domestic Partner is eligible for coverage as any other Dependent Child if the Domestic Partner meets the qualifications for coverage and the child of the Domestic Partner meets the eligibility requirements of a Dependent Child of a Domestic Partner.

**Dependent Child of a Domestic Partner** means an individual who:

a. **Is:**
   
   i. The natural child, stepchild, adopted child, or grandchild of the Subscriber's eligible Domestic Partner;
   
   ii. A child (including a grandchild) placed with the Subscriber's eligible Domestic Partner for legal adoption; or
   
   iii. An individual under testamentary or court appointed guardianship, other than temporary guardianship for less than twelve (12) months duration, of the Subscriber's eligible Domestic Partner.

b. Has not provided over one-half of his/her own support for the previous calendar year.

c. Is unmarried; and

d. Is under the Limiting Age of twenty-five (25) stated in the attached Eligibility Schedule attached to this Certificate of Coverage; or

e. Is a child who is the subject of a Medical Child Support Order that creates or recognizes the right of the child to receive benefits under the health insurance coverage of the Subscriber's covered Domestic Partner.

Children whose relationship to the Subscriber's Domestic Partner is not listed above, including, but not limited to foster children or children whose only relationship is one of legal guardianship (except as provided above) are not covered under this Certificate of Coverage, even though the child may live with the Subscriber's Domestic Partner and be dependent upon the Subscriber's Domestic Partner for support.

3. **Enrollment Opportunities.** The terms and conditions for the enrollment, including special and late enrollment (if applicable), of a Domestic Partner and the Dependent Child of a Domestic Partner under the Certificate of Coverage will be the same, respectively, as that of a Subscriber's spouse and the eligible Dependent Child of a Subscriber's spouse.

**First Eligibility Date** for an eligible:

a. Domestic Partner shall be the date established by the Group's enrollment procedures.
b. Dependent Child of a Domestic Partner shall be the same as that of the Domestic Partner if, on the Domestic Partner's First Eligibility Date, the child meets the definition of a Dependent Child of a Domestic Partner as stated in this rider. Otherwise, the First Eligibility Date for the child will be the date on which the child first meets the definition of Dependent Child of a Domestic Partner as stated in this rider.

SECTION C - CONTINUATION OF COVERAGE

The Certificate of Coverage is amended to include the following:

1. **Federal Continuation Coverage.** If the Group is subject to COBRA, continuation coverage under COBRA will be made available by the Group to Domestic Partners and will be made available by the Group to Dependent Children of Domestic Partners. If the Group chooses to make COBRA continuation coverage available to Domestic Partners and Dependent Children of Domestic Partners, the terms and conditions of the continuation coverage will be the same as the terms and conditions of COBRA continuation coverage offered to a Subscriber's spouse and the Dependent Child of a Subscriber's spouse.

2. **Maryland Continuation Coverage.** The provisions in the Certificate of Coverage regarding Maryland continuation coverage are applicable to a Domestic Partner and the Dependent Child of a Domestic Partner. The terms and conditions of the continuation coverage for Domestic Partners and the Dependent Children of a Domestic Partner will be the same as the terms and conditions of continuation coverage provided, respectively, to a Subscriber's spouse and the Dependent Children of a Subscriber's spouse.

SECTION D - CONVERSION PRIVILEGE

The Certificate of Coverage is amended to include the following:

1. Following the death of a Subscriber, the enrolled Domestic Partner, or if there is no Domestic Partner, the covered Dependent Children of a Domestic Partner, may purchase a Conversion Contract.

2. If the Domestic Partner's coverage terminates due to a failure to continue to meet the eligibility requirements of a Domestic Partnership under the terms of this rider, the Domestic Partner is not entitled to purchase a Conversion Contract.

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

Group Hospitalization and Medical Services, Inc.

[Signature]

Chester E. Burrell
President and Chief Executive Officer
ATTACHMENT D
ELIGIBILITY SCHEDULE

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Effective as of the Effective Date of Your Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Renewal Date</td>
<td>July 1, 2011</td>
</tr>
</tbody>
</table>

**DEFINITIONS**

**Preexisting Condition.** A condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received by a licensed practitioner within a 6-month period ending on the Enrollment Date. A Preexisting Condition will not include pregnancy.

A preexisting condition will not be found solely because the Member has been diagnosed as having a fibrocystic condition, nonmalignant lesion, or a family history related to breast cancer or solely due to breast cancer, if the insured has been free from breast cancer for a period of five years or more prior to the date of the application for coverage. Additionally, follow-up care, used to determine whether breast cancer has recurred in a person who has been previously determined to be free of breast cancer, as evidence by a negative follow-up for at least 5 years, shall not constitute medical advice, diagnosis, care or treatment for the purposes of determining a preexisting condition unless evidence of breast cancer is found during, or as a result of, the follow-up care.

**Enrollment Date.** The first day of coverage or if there is a Waiting Period, the first day of the Waiting Period. This runs concurrently with the Preexisting Condition Exclusion Period.

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

**Preexisting Condition Exclusion Period.** The period of time, beginning on the Enrollment Date, during which coverage for Preexisting Conditions will not be provided under this Group Contract. For the purposes of calculating the Preexisting Condition Exclusion Period, any time satisfied under the Waiting Period will count toward satisfying the Preexisting Condition Exclusion Period.

**Creditable Coverage.** Means coverage of an individual under any of the following: a group health plan (including employer sponsored, governmental and church plans); health insurance coverage (including group, individual, and short-term, limited duration coverage); State Children's Health Insurance Program (S-CHIP); Medicare; Medicaid; CHAMPUS; a medical program of the Indian Health Service or a tribal organization; a state health benefits risk pool; the Federal Employees Health Benefits Program (FEHBP), a public health plan as defined by federal regulations authorized by the public health service act, section 2701(c)(1)(i), as amended by P.L. 104-191; or health benefit plans offered by the Peace Corps.

**Significant Break in Coverage.** The period of 63 consecutive days during all of which the individual does not have any Creditable Coverage. The Waiting Period is not taken into account in determining the Significant Break in Coverage.
### Eligibility

| Subscriber | A full-time wage-earning employee; who works at least 30 hours per week on a regular (not seasonal or temporary) basis. An eligible employee or eligible participant of the Group, who is subject to the provisions of the Family and Medical Leave Act of 1993, as stated therein. NOTE: A wage earning employee is a person who is compensated for work/services performed in accordance with applicable federal and state wage and hour laws, which compensation is reported to the Internal Revenue Service by Form W-2 and the Department of Business and Economic Development by Form DEED/AU-16. A part-time wage-earning employee who works at least 17.50 hours per week on a regular (not seasonal or temporary) basis for more than six months each year. Retirees who have retired prior to the effective date of this coverage. Retirees who retire on or after the effective date of this coverage. |
| Spouse | Coverage for a spouse is available. |
| Domestic Partner | Coverage for Domestic Partner is available. |
| Dependent Children | Coverage for Dependent Children of a Domestic Partner is available. |
| Type of Coverage | Individual, Individual & Child, Individual & Adult, Family |
| Individuals covered under prior continuation provision | Coverage for a person whose coverage was being continued under a continuation provision of the Group's prior health insurance plan is available. |
| Limiting Age for Dependent children (other than incapacitated children) | Age 26 |

### Effective Dates

<p>| Open Enrollment Effective Date | June 1, 2011 |
| Existing Subscriber Effective Date | An existing Subscriber is eligible for coverage on the effective date of the Group |
| Existing Dependent Effective Date | An existing Dependent is eligible for coverage on the effective date of the Group |
| Newly Eligible Subscriber Effective Date | A new Subscriber is eligible for coverage effective on the first day of the month following or coincident with date of hire. |</p>
<table>
<thead>
<tr>
<th>Newborn Dependent Child or Grandchild, Newly Adopted Dependent Child or Grandchild, Newly Eligible Dependent Child or Grandchild, a Minor Dependent Child for whom Guardianship Has Been Granted by Court or Testamentary Appointment, or Child Subject to a MCSO/QMSO</th>
<th>Newly born Dependent Child or Grandchild (or newborn grandchild who is a dependent of the Subscriber or Dependent spouse): the date of birth. Adopted Dependent Child or Grandchild: the date of adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent. Testamentary or court appointed guardianship of a Dependent Child: the date of appointment. Dependent child who is the subject of a Medical Child Support Order or Qualified Medical Support Order that creates or recognizes the right of the Dependent child to receive benefits under a parent's health insurance coverage: Medical Child Support Order: the date specified in the Medical Child Support Order. Qualified Medical Support Order: the date specified in the Qualified Medical Support Order. A Newly Eligible Dependent Child or Grandchild (non-newborn) who is the dependent of, the Subscriber or Dependent spouse: the date the child or grandchild became a dependent of Subscriber or Dependent spouse.</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Family Member (other than Newborn Dependent Child or Grandchild, Newly Adopted Dependent Child or Grandchild, Newly Eligible Dependent Child or Grandchild, a Minor Dependent Child for whom Guardianship Has Been Granted by Court or Testamentary Appointment, or Child Subject to a MCSO/QMSO)</td>
<td>The date first eligible.</td>
</tr>
</tbody>
</table>

**SPECIAL ENROLLMENT PERIODS**

<table>
<thead>
<tr>
<th>Subscriber or Dependent did not select coverage when first eligible because the Subscriber or Dependent already had coverage under another employer sponsored plan or group health benefits plan (except for those who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility)</th>
<th>Coverage for a new Subscriber and/or Dependent eligible for special enrollment because of termination of other coverage is effective on the first of the month following acceptance of the enrollment form by CareFirst.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber eligible for coverage but not enrolled and an individual becomes his/ her Dependent by marriage or becomes his/ her Dependent Child (except for those who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility)</td>
<td>Coverage for the Subscriber and new Spouse eligible for special enrollment is effective on the first of the month following the date CareFirst receives the completed enrollment form. Coverage for the Subscriber and the Dependent is effective on the date of birth, the date of Adoption or placement for Adoption, whichever occurs first, the date the Dependent Child first became a dependent of the Subscriber or Spouse, the date of guardianship, or the date specified in the MCSO/QMSO.</td>
</tr>
<tr>
<td>Basis of Enrollment</td>
<td>Preexisting Condition Exclusion Periods</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Timely Enrollment</strong></td>
<td></td>
</tr>
<tr>
<td>Initial Enrollment</td>
<td>There is no Preexisting Condition Exclusion Period for Preexisting Conditions.</td>
</tr>
<tr>
<td>Newly Eligible Subscriber</td>
<td>There is no Preexisting Condition Exclusion Period for Preexisting Conditions.</td>
</tr>
<tr>
<td>Domestic Partners</td>
<td>There is no Preexisting Condition Exclusion Period for Preexisting Conditions.</td>
</tr>
<tr>
<td>Coverage of a Newborn Dependent Child or Grandchild, Newly Adopted Dependent Child or Grandchild, Newly Eligible Dependent Child or Grandchild, a Minor Dependent Child for whom Guardianship Has Been Granted by Court or Testamentary Appointment.</td>
<td>There is no Preexisting Condition Exclusion Period for Preexisting Conditions.</td>
</tr>
<tr>
<td>Court-Ordered Coverage (including coverage ordered pursuant to an MCSO/QMSO)</td>
<td>There is no Preexisting Condition Exclusion Period for Preexisting Conditions.</td>
</tr>
<tr>
<td>New Family Member (other than Newborn Dependent Child or Grandchild, Newly Adopted Dependent Child or Grandchild, Newly Eligible Dependent Child or Grandchild, a Minor Dependent Child for whom Guardianship Has Been Granted by Court or Testamentary Appointment)</td>
<td>There is no Preexisting Condition Exclusion Period for Preexisting Conditions.</td>
</tr>
<tr>
<td><strong>Special Enrollment Periods</strong></td>
<td></td>
</tr>
<tr>
<td>Subscriber or Dependent did not select coverage when first eligible because the Subscriber or Dependent already had coverage under another employer sponsored plan or group health benefits plan (except for those who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility)</td>
<td>There is no Preexisting Condition Exclusion Period for Preexisting Conditions.</td>
</tr>
<tr>
<td>Subscriber eligible for coverage but not enrolled and an individual becomes his or her Dependent by marriage or becomes his or her Dependent Child (except for those who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility)</td>
<td>There is no Preexisting Condition Exclusion Period for Preexisting Conditions.</td>
</tr>
<tr>
<td>Subscribers or Dependents who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility</td>
<td>There is no Preexisting Condition Exclusion Period for Preexisting Conditions.</td>
</tr>
</tbody>
</table>
### Late Enrollment

| Late Enrollees | A 12 month Preexisting Condition Exclusion Period will apply to any Preexisting Condition. The Preexisting Condition Exclusion Period will be waived if you had any prior Creditable Coverage, unless there is a Significant Break in Coverage immediately preceding your Enrollment Date. |

### TERMINATION OF COVERAGE

<table>
<thead>
<tr>
<th>Subscriber No Longer Eligible</th>
<th>Coverage ends on the last day of the month in which employment or eligibility terminates.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Child (Other than an Incapacitated Child)</td>
<td>End of the month following their 26th birthday.</td>
</tr>
<tr>
<td>Other Dependent no longer eligible (Includes Marriage of Child or Divorce of Spouse)</td>
<td>A Dependent will remain covered until the end of the month in which the Dependent no longer meets the eligibility requirements stated in the Evidence of Coverage.</td>
</tr>
<tr>
<td>Upon Death of Subscriber</td>
<td>Coverage ends on the last day of the month after the Subscriber’s death</td>
</tr>
</tbody>
</table>