Group Hospitalization and Medical Services, Inc.

doing business as
CareFirst BlueCross BlueShield (CareFirst)

1440 G Street, NW
Washington, DC 20005
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE
FOR A QUALIFIED HEALTH PLAN

This Qualified Health Plan is being offered through the SHOP Exchange.

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

CareFirst recommends that the Member familiarizes himself or herself with the CareFirst complaint and appeal procedure, and make use of it before taking any other action.

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

Group Name:	Sample
Group Number:	Sample
Product Name:	BluePreferred PPO Gold 1300 Ded
Group Effective Date:	January 1, 2027

Group Hospitalization and Medical Services, Inc.

[Signature]

[Name]
[Title]

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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.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152).

Allowed Benefit means:

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

B. For a Non-Preferred Provider that is a health care practitioner, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the provider at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the practitioner's actual charge. The provider may bill the Member directly for such amounts. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Provider charge.

C. For a Non-Preferred Provider that is a health care facility, the Allowed Benefit for a Covered Service is based upon either the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the facility, at the discretion of CareFirst. Benefit payments to Department of Defense and Veteran Affairs providers will be made directly to the provider. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the provider's actual charge. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Facility.

   In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment, or Coinsurance amounts, for which the Member is responsible.

D. For a Covered Service rendered by a Non-Preferred Provider of ambulance services, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the Non-Preferred Provider of ambulance services, at the discretion of CareFirst. When benefits are paid to the Member, it is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Provider of ambulance services. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the provider's actual charge. The provider may bill the Member directly for such amounts.

   For Emergency Services provided by a Non-Preferred Provider, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge, or the amount that would be paid to a Preferred Provider for the Covered Service. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the practitioner's actual charge. The provider may bill the Member directly for such amounts.

Pediatric Dental Allowed Benefit means:

A. For Preferred Dentists, the Allowed Benefit payable to a Preferred Dentist for a Covered Dental Service will be the amount agreed upon between CareFirst and the Preferred Dentist. The benefit payment is made directly to the Preferred Dentist and accepted as payment in full, except for any applicable Deductible and Coinsurance for which the Subscriber is responsible as stated in the Schedule of Benefits. The Subscriber is responsible for any applicable Deductible and Coinsurance, and both Preferred and Non- Preferred Dentists may bill the Subscriber directly for such amounts.

B. For Participating Dentists, the Allowed Benefit payable to a Participating Dentist for a Covered Dental Service will be the lesser of (1) the Dentist's actual charge; or (2) the benefit amount, according to the CareFirst rate schedule for the Covered Dental Service that applies on the date the service is rendered. The benefit amount on the CareFirst rate schedule will be no less than the amount paid to a Preferred Dentist in the same geographic area for the same service. The benefit payment is made directly to the Participating Dentist and is accepted as payment in full, except for the Deductible and Coinsurance amounts stated in the Schedule of Benefits. The Subscriber is responsible for any applicable Deductible and Coinsurance and the Participating Dentist may bill the Subscriber directly for such amounts.

C. For Non-Participating Dentists, the Allowed Benefit payable to a Non-Participating Dentist for a Covered Dental Service will be determined in the same manner as the Allowed Benefit payable to a Participating Dentist. For a Non-Participating Dentist who is a physician, the benefit is payable to the physician if the Subscriber has given an Assignment of Benefits or, otherwise, to the Subscriber or the Non-Participating Dentist at the discretion of CareFirst. For any other Non-Participating Dentist, the benefit is payable to the Subscriber or to the Non-Participating Dentist at the discretion of CareFirst. The Subscriber is responsible for payment for services to the Non- Participating Dentist, including any applicable Deductible and Coinsurance amounts as stated in the Schedule of Benefits and for any balance bill amounts. The Non- Participating Dentist may bill the Subscriber directly for such amounts. It is the Subscriber's responsibility to apply any CareFirst payments to the claim from the Non- Participating Dentist.

Prescription Drug Allowed Benefit means the lesser of:

A. The Pharmacy's actual charge; or

B. The benefit amount, according to the CareFirst fee schedule, for covered Prescription Drugs that applies on the date the service is rendered.

If the Member purchases a covered Prescription Drug or diabetic supply from a Contracting Pharmacy Provider, the benefit payment is made directly to the Contracting Pharmacy Provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance and the Contracting Pharmacy Provider may bill the Member directly for such amounts.

If the Member purchases a covered Prescription Drug from a Non-Contracting Pharmacy 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, Copayment, or Coinsurance. Members may be responsible for balances above the Allowed Benefit.

Vision Allowed Benefit means:

A. For a Contracting Vision Provider, the Vision Allowed Benefit for a covered service is the lesser of:

   1. The actual charge; or

   2. The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date the service is rendered.

The benefit payment is made directly to a Contracting Vision Provider. When a Member receives Covered Vision Services from a Contracting Vision Provider, the benefit payment is accepted as payment in full, except for any applicable Copayment. When a Member receives frames and spectacle lenses or contact lenses from a Contracting Vision Provider, the benefit payment is as stated in the Schedule of Benefits below. The Contracting Vision Provider may collect any applicable Copayment or amounts in excess of the Vision Care Designee's payment when other frames and non-standard spectacle lenses or other contact lenses are purchased by the Member.

B. For a Non-Contracting Vision Provider, the Allowed Benefit for Vision Care will be determined in the same manner as the Allowed Benefit to a Contracting Vision Provider.

Benefits may be paid to the Subscriber or to the Non-Contracting Vision 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 Vision Provider's actual charge. The Non-Contracting Vision Provider may bill the Member directly. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Contracting Vision Provider.

Annual Open Enrollment Period means the period of no less than thirty (30) days each year prior to the Group's Contract Renewal Date during which an individual may enroll or change coverage in this Qualified Health Plan through the SHOP Exchange.

Benefit Period means the Contract Year during which coverage is provided for Covered Services, Covered Prescription Drugs, Covered Dental Services and Covered Vision Services .

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.

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 may be used and protected by a trademark.

Calendar Year means January 1 through December 31 of each 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.

Civil Union means a same-sex relationship similar to marriage that is recognized by law. The Subscriber's partner in a Civil Union is eligible for coverage to the same extent as an eligible Spouse.

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, Covered Prescription Drugs, Covered Dental Services, or Covered Vision Services.

Contract Renewal Date means the date on which the Group Contract renews and each anniversary of such date.

Contract Year means the twelve (12) month period beginning on the Group Effective Date.

Contracting Pharmacy Provider means the separate independent Pharmacist or Pharmacy, including a pharmacy in the Exclusive Specialty Pharmacy Network, that has contracted with CareFirst or its designee to provide Prescription Drugs in accordance with the terms of this Evidence of Coverage.

Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are rendered when acting

within the scope of such license and that has contracted with the Vision Care Designee to provide Covered Vision Services.

Convenience Item means personal hygiene and convenience items, including, but not limited to: air conditioners, humidifiers, physical fitness equipment, elevators, hoyer/stair lifts, ramps, shower/bath benches, and items available without a prescription.

Copayment (Copay) means the fixed dollar amount that a Member must pay for certain Covered Services, Covered Prescription Drugs, Covered Dental Services, or Covered Vision Services.

Cosmetic means 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 Dental Services means Medically Necessary services or supplies listed in Section 2 of the Description of Covered Services.

Covered Prescription Drug means a Prescription Drug included in the CareFirst Formulary.

Covered Service means Medically Necessary services or supplies provided in accordance with the terms of this Evidence of Coverage other than Covered Dental Services or Covered Vision Services.

Covered Specialty Drug means a Specialty Drug included in the CareFirst Formulary.

Covered Vision Services means Medically Necessary services or supplies listed in Section 3 of the Description of Covered Services.

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 not requiring continuing services of medically trained personnel.

Decertification or Decertified means the termination by the SHOP Exchange of the certification and offering of this Qualified Health Plan.

Deductible means the dollar amount of the Allowed Benefits payable during a Benefit Period for Covered Services or Covered Dental Services that must first be incurred by the Member before CareFirst will make payments for Covered Services or Covered Dental Services.

Dental Director is a Dentist appointed by the Medical Director of CareFirst to perform administrative duties with regard to the dental services listed in this Evidence of Coverage.

Dentist means an individual who is licensed to practice dentistry as defined by the respective jurisdiction where the practitioner provides care.

Dependent means a Member who is covered as an eligible Spouse or Dependent Child as defined in Sections 2.2 and 2.3. The eligibility of Dependents to enroll is stated in the Eligibility Schedule. Dependent Child or Dependent Children means one or more eligible individuals as defined in Section 2.3.

Diabetes Device means a legend device or non-legend device used to cure, diagnose, mitigate, prevent or treat diabetes or low blood sugar. The term includes a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device, or insulin syringe.

Diabetic Ketoacidosis Device means a device that is a legend or non-legend device aid used to screen for or prevent diabetic ketoacidosis. The term includes diabetic ketoacidosis devices prescribed and dispensed once during a policy year.

Diabetic Supply or Diabetic Supplies means all Medically Necessary and appropriate supplies prescribed by a health care provider for the treatment of diabetes, including but not limited to lancets, alcohol wipes, test strips (blood and urine), syringes and needles

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

Emergency Medical Condition means:

A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or

B. With respect to a pregnant woman who is having contractions: there is inadequate time to effect a safe transfer to another hospital before delivery, or transfer may pose a threat to the health or safety of the woman or the unborn child.

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

A. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition;

B. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

C. Except as provided in item 4. below, covered services that are furnished by a non- participating provider or non-contracting emergency facility after the individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in item 1. above are furnished.

D. The covered services described in item 3. above are not included as emergency services if all of the following conditions are met:

1. The attending emergency physician or treating provider determines that the individual is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition;

2. The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 C.F.R § 149.420(c) through (g) with respect to such items and services, provided that the written notice additionally satisfies items 4.b.i. and ii. below, as applicable;

i. In the case of a participating emergency facility and a non- participating provider, the written notice must also include a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

ii. In the case of a non-contracting emergency facility, the written notice must include the good faith estimated amount that the individual may be charged for items or services furnished by the non-contracting emergency facility or by non-contracting providers with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by the non-contracting

emergency facility or non-contracting providers in conjunction with such items or services);

3. The individual (or an authorized representative of such individual) is in a condition to receive the information described in item b. above, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law.

Evidence of Coverage means this agreement, including all duly authorized attachments, notices, amendments and riders, issued to the Group and the Subscriber by CareFirst under the Group Contract between the Group and CareFirst.

Exclusive Specialty Pharmacy Network means a pharmacy network that is limited to certain specialty Pharmacies that have been designated as "Exclusive" by CareFirst. Members may contact CareFirst for a list of Pharmacies in the Exclusive Specialty Pharmacy Network.

Experimental/Investigational means a service or supply in the developmental stage and in the process of human or animal testing excluding patient costs for clinical trials 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.

Facility means

A. a hospital (as defined in section 1861(e) of the Social Security Act),

B. a hospital outpatient department,

C. a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act), or

D. an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act).

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.

FDA means the United States Food and Drug Administration.

Formulary means the means the list of Prescription Drugs issued by CareFirst and used by health care providers when writing, and Pharmacists, when filling, prescriptions for which coverage will be provided under this Evidence of Coverage. CareFirst may change this list periodically without notice to Members. A copy of the Formulary is available to the Member upon request.

Generic Drug means any Prescription Drug approved by the FDA that has the same bio-equivalency as a specific Brand Name Drug.

Group means the Qualified Employer to which CareFirst has issued the Group Contract and the Evidence of Coverage.

Group Contract means the contract, including all duly authorized attachments, notices, amendments and riders, between the Group and CareFirst.

Group Contract Effective Date means the effective date of the Group Contract.

Habilitative Services means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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:

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

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

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

Infusion Services means treatment provided by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. Infusion Services include all medications administered intravenously and/or parenterally.

Limiting Age means the maximum age up to which a Dependent Child may be covered as stated in the Eligibility Schedule.

Low Vision means a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in Low Vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with Low Vision.

Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.

Mastectomy means the surgical removal of all or part of the breast.

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

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 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 that are at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of the patient's illness, injury, or disease.

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

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

Medical Nutrition Therapy provided by a licensed dietitian-nutritionist involves the assessment of the Member's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. The licensed dietitian-nutritionist, working in a coordinated, multidisciplinary team effort with the Primary Care Physician takes into account a Member's condition, food intake, physical activity, course of any medical therapy, including medications and other treatments, individual preferences, and other factors.

Medication-Assisted Treatment (MAT) means Prescription Drugs used to treat Substance Use Disorders (Alcohol Use Disorder and opioid use disorder).

Member means an individual who meets all applicable eligibility requirements of Section 2, is enrolled for coverage and for whom the CareFirst receives the premiums and other required payments. A Member can be either a Subscriber or Dependent.

Minimum Essential Coverage has the meaning given in the Affordable Care Act, 26 U.S.C. §5000A(f).

Non-Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are 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 Covered Vision Services. A Non-Contracting Vision Provider may or may not have contracted with CareFirst. The Member should contact the Vision Care Designee for the current list of Contracting Vision Providers.

Non-Participating Dentist means any Dentist who, at the time of rendering a Covered Dental Service to the Member, does not have a written agreement with CareFirst or CareFirst's designee for the rendering of such service.

Non-Preferred Brand Name Drug means a Brand Name Drug included in the Formulary as a Covered Prescription Drug but not included on the Preferred Drug List.

Non-Preferred Dentist means any Dentist who is not a Preferred Dentist, including a Participating Dentist and a Non-Participating Dentist.

Non-Preferred Provider means a health care provider that does not contract with CareFirst to provide Covered Services. Neither Participating Dentists or Non-Participating Dentists who provide Covered Dental Services nor Non-Contracting Vision Providers who provide Covered Vision Services are Non-Preferred Providers for the purposes of this definition.

Non-Preferred Specialty Drug means a Specialty Drug included in the Formulary as a Covered Prescription Drug but not included on the Preferred Drug List.

Opioid Reversal Agents means Prescription Drugs used to reverse an opioid overdose.

Out-of-Pocket Maximum means the maximum amount the Member will have to pay for his/her share of benefits in any Benefit Period. The Out-of-Pocket Maximum does not include premiums, the cost of services that are not Covered Services, or any amounts paid to providers in excess of the Allowed Benefit, the Pediatric Dental Allowed Benefit, the Vision Allowed Benefit or the Prescription Drug Allowed Benefit. Once the Member meets the Out-of-Pocket Maximum, the Member will no longer be required to pay Copayments, Coinsurance or Deductible for the remainder of the Benefit Period.

Over-the-Counter means any item or supply, as determined by CareFirst, 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 items for men, 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 related over-the-counter medications, solutions, items or supplies.

Participating Dentist means any Dentist who, at the time of rendering a Covered Dental Service to the Member, has a written agreement with CareFirst or CareFirst's designee for the rendering of such service.

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 Dentist means one of a network of Participating Dentists who, at the time of rendering a Covered Dental Service to the Member, has a written agreement with CareFirst, or CareFirst's designee, for the rendering of such service.

Preferred Drug List means the list of Preferred Drugs issued by CareFirst and used by health care providers when writing, and Pharmacists, when filling, prescriptions. All Generic Drugs are included in the Preferred Drug List. Not all Brand Name Drugs listed in the Formulary 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.

Preferred Provider means a health care provider that has contracted with CareFirst to render Covered Services to Members. A Preferred Dentist who provides Covered Dental Services or a Contracting Vision Provider who provides Covered Vision Services is not a Preferred Provider for the purposes of this definition. Preferred Provider relates only to method of payment, and does not imply that any physician, health care professional or health care facility is more or less qualified than another.

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.

Preferred Specialty Drug means a Specialty Drug included in the Preferred Drug List.

Prescription Drug means:

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

B. Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst;

C. A covered Over-the-Counter medication or supply; or

D. Any Diabetic Supply.

E. Prescription Drugs do not include:

1. Compounded bulk powders that contain ingredients that:

a) Do not have FDA approval for the route of administration being compounded, or

b) Have no clinical evidence demonstrating safety and efficacy, or

c) Do not require a prescription to be dispensed.

2. Compounded drugs that are available as a similar commercially available Prescription Drug unless:

a) There is no commercially available bioequivalent Prescription Drug; or

b) The commercially available bioequivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

Prescription Guidelines means the limited list of Prescription Drugs issued by CareFirst for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from CareFirst and the quantity limits that CareFirst has placed on certain drugs. A copy of the Prescription Guidelines is available to the Member upon request.

Preventive Drug means a Prescription Drug or Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is included on the CareFirst Preventive Drug List.

Preventive Drug List means the list issued by CareFirst of Prescription Drugs or Over-the-Counter medications or supplies dispensed under a written prescription by a health care provider that have been identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration.

For plans that include coverage for select generic drugs, the list includes certain generic drugs used to treat chronic conditions.

CareFirst may change this list periodically and without notice to Members. A copy of the Preventive Drug List and $0 Select Generics List is available to the Member upon request.

Primary Care Dependent means an unmarried grandchild, niece or nephew for whom the Subscriber provides primary care including food, shelter and clothing on a regular and continuous basis during the time the District of Columbia public schools are in regular session.

Primary Care Physician (PCP) means health care practitioners in the following disciplines:

A. General internal medicine;

B. Family practice medicine;

C. General pediatric medicine; or

D. Geriatric medicine.

Services rendered by Specialists in the disciplines above will be treated as PCP visits for Member payment purposes.

Professional Nutritional Counseling means individualized advice and guidance given to a Member who is at nutritional risk due to nutritional history, current dietary intake, medication use, or chronic illness or condition, about options and methods for improving nutritional status. Professional Nutritional

Counseling must be provided by a licensed dietitian-nutritionist, physician, physician assistant, or nurse practitioner.

Qualified Employee means an eligible individual who has been offered health insurance coverage by the Group through the SHOP Exchange. The Group's eligibility requirements for a Qualified Employee are stated in the Eligibility Schedule.

Qualified Employer means the employer that the SHOP Exchange has determined to be qualified to offer Qualified Health Plan(s).

Qualified Health Plan means a health plan certified by the SHOP Exchange as having met the standards established by the U.S. Department of Health and Human Services.

Qualified Home Health Agency means a licensed program 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.

Qualified Hospice Care Program means a coordinated, interdisciplinary program provided by a hospital, Qualified Home Health Agency, or other health care facility 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. Benefits are available to:

A. Individuals who have no reasonable prospect of cure as estimated by a physician; and

B. The immediate families or Family Caregivers of those individuals.

Qualified Medical Support Order (QMSO) means a Medical Child Support Order, issued under state law or the laws of the District of Columbia, that is 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.

Qualified Payment Amount means an amount calculated based on the median contracted rate for all plans offered by CareFirst in the same insurance market for the same or similar item or service that is:

A. Provided by a provider in the same or similar specialty or facility of the same or similar facility type; and

B. Provided in the geographic region in which the item or service is furnished.

Recognized Amount means an amount determined as follows:

A. In a state or jurisdiction that has an applicable All-Payer Model Agreement, the amount that the state or jurisdiction approves under the All-Payer Model Agreement for the particular Covered Service.

B. If there is no applicable All-Payer Model Agreement, in a state or jurisdiction that has in effect an applicable law, the amount for the Covered Service determined in accordance with the law.

C. If neither an applicable All-Payer Model Agreement nor law apply to the specific Covered Service, the lesser of:

    1. The Non-Preferred Health Care Provider's actual charge; or

    2. The Qualifying Payment Amount

Rescind or Rescission means a termination, cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's or group's enrollment is a Rescission. As another example, a cancellation that voids benefits

paid up to a year before the cancellation is also a Rescission for this purpose. Coverage is not Rescinded and a cancellation or discontinuance of coverage is not a Rescission if:

A. The termination, cancellation or discontinuance of coverage has only a prospective effect; or

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

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

Service Area means the clearly defined geographic area in which CareFirst has arranged for the provision of health care services to be generally available and readily accessible to Members, except for emergency 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; in the Commonwealth of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince Williams Counties in Virginia lying east of Route 123.

SHOP Exchange means the District of Columbia Health Benefit Exchange (DC HBX).

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) accredited or approved under Medicare or The Joint Commission and provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care, or rehabilitation services. 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.

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

Special Enrollment Period means a period during which an eligible individual who experiences certain qualifying events may enroll in, or change enrollment in, a Qualified Health Plan through the SHOP Exchange outside of any Annual Open Enrollment Periods.

Specialist means a licensed health care provider who is certified or trained in a specified field of medicine.

Specialty Drugs means high-cost injectables, infused, oral, or inhaled Prescription Drugs for the ongoing treatment of a complex or chronic condition or a rare medical condition, including but not limited to, the following: Hemophilia, Hepatitis C, Multiple Sclerosis, Rheumatoid Arthritis, Psoriasis, Crohn's Disease, Cancer (oral medications), and Growth Hormones. These Prescription Drugs usually require specialized handling (such as refrigeration) and may not be stocked at a retail pharmacy. Drugs for the treatment of HIV, AIDS, or diabetes are not considered Specialty Drugs.

Spouse means a person of the same or opposite sex who is legally married to the Subscriber under the laws of the state or jurisdiction in which the marriage took place. A marriage legally entered into in another jurisdiction will be recognized as a marriage in the District of Columbia. The Subscriber's partner in a Civil Union is eligible for coverage to the same extent as an eligible Spouse. If the policy includes the Domestic Partner Eligibility Rider, the Subscriber's partner domestic partnership is eligible for coverage to the same extent as an eligible Spouse. Whenever the term Spouse appears in the Policy, this provision includes the Definition of registered domestic partner and civil union partner into the Policy.

Subscriber means a Member who is enrolled as a Qualified Employee or eligible former Qualified Employee rather than as a Dependent.

Substance Use Disorder means:

A. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or

B. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the hospital emergency room. An Urgent Care facility is a freestanding facility that is not a physician's office and which provides Urgent Care.

Vision Care Designee means the entity with which CareFirst has contracted to administer Vision Care. CareFirst's Vision Care Designee is Davis Vision, Inc. Davis Vision, Inc. is an independent company and administers the Vision Care benefits on behalf of CareFirst.

Waiting Period means the period of time, stated in the Eligibility Schedule, that must pass before a Qualified Employee or any Dependent is eligible for coverage under the terms of the Group Contract.

SECTION 2
ELIGIBILITY AND ENROLLMENT

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

A. A Subscriber must be an eligible Qualified Employee of the Group. To enroll as a Subscriber, the individual must, at the time of enrollment, meet the eligibility requirements established by the Group. The Group's eligibility requirements for a Qualified Employee are stated in the Eligibility Schedule.

B. Any other Member must be an eligible individual who is a Dependent of a Subscriber. To enroll as a Dependent, the individual must, at the time of enrollment meet the eligibility requirements established by the Group. The eligibility of Dependents to enroll is stated in the Eligibility Schedule.

C. For each Subscriber and Member, the SHOP Exchange must receive premium payments as required by the Group Contract.

2.2 Eligibility of Subscriber's Spouse. If the Group has elected to include coverage for the Subscriber's Spouse, then a Subscriber may enroll a Spouse as a Dependent. A Subscriber cannot cover a former Spouse once divorced or if the marriage had been annulled. Premium changes resulting from the enrollment of a Spouse will be effective as of the Effective Date of the Spouse's enrollment.

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

A. Is:

1. The natural child, stepchild, or adopted child of the Subscriber;

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

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

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

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

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

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

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

reserves the right to verify whether the child is and continues to qualify as a Primary Care Dependent, and

5. A child who becomes a Dependent of the Subscriber through a child support order (MCSO or QMSO) or other court order.

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

C. Is a disabled Dependent Child who is older than the Limiting Age 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) the Dependent Child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse for support and maintenance; and (3) the Dependent Child had been covered under the Subscriber's or the Subscriber's Spouse's prior health insurance coverage since before the onset of the mental or physical incapacity.

D. Is the subject of a Medical Child Support Order (MCSO) or 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.

E. A child whose relationship to the Subscriber 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) is not eligible to enroll and is not covered under this Evidence of Coverage, even though the child may live with the Subscriber and be dependent upon him or her for support.

2.4 Limiting Age for Covered Dependent Children.

A. All covered Dependent Children are eligible for coverage up to the Limiting Age for Dependent Children as stated in the Eligibility Schedule. When a Dependent Child reaches the Limiting Age enrollment terminates on December 31 of the Calendar year in which the Dependent Child reached the Limiting Age, unless otherwise instructed by the SHOP Exchange.

B. A Dependent Child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if, at the time coverage would otherwise terminate:

1. The Dependent Child is unmarried and is incapable of self-support or maintenance because of a 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 mental or physical incapacity occurred before the covered Dependent Child reached the Limiting Age; and

4. The Subscriber provides CareFirst with proof of the Dependent Child's mental or physical incapacity within thirty-one (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 Evidence of Coverage or the Eligibility Schedule. Coverage of an ineligible Dependent will terminate as stated in the Eligibility Schedule.

2.5 Open Enrollment Opportunities and Effective Dates. A Qualified Employee may elect coverage for himself or herself or for an eligible Dependent only during the following times and under the following conditions.

A. Annual Open Enrollment. During an Annual Open Enrollment Period, a Qualified Employee or eligible individual may enroll as a Subscriber or Member.

B. Newly Eligible Subscriber. If a Qualified Employee is a new employee or a newly eligible employee of the Group, the new Qualified Employee may enroll him or herself and any eligible Dependent within thirty (30) days after a new Qualified Employee first becomes eligible. The eligibility requirements for a new Qualified Employee in the Group are stated in the Eligibility Schedule.

C. Special Enrollment. If a Qualified Employee or Dependent does not enroll during an Annual Open Enrollment Period or during the enrollment period for newly eligible Qualified Employees, he or she may only enroll during a Special Enrollment Period

1. Thirty (30) or Thirty-One (31) Day Special Enrollment Period. Except as otherwise specified, an eligible individual may enroll as a Subscriber or Dependent upon the occurrence of one of the following qualifying events:

a) The Qualified Employee or a Dependent:

(1) Loses Minimum Essential Coverage. A loss of Minimum Essential Coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii).

Loss of coverage described herein includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii) and in paragraphs (d)(1)(ii) through (iv) of 45 CFR §155.420. Loss of coverage does not include voluntary termination of coverage or other loss due to:

(a) Failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage; or

(b) Situations allowing for a Rescission.

(2) Loses pregnancy-related coverage described in 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)). The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or

(3) Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage.

(4) At the option of the SHOP Exchange, the enrollee who is the Qualified Employee or the Spouse of the Qualified Employee if the enrollee loses a Dependent or is no longer considered to be a Dependent due to divorce or legal separation; or if the employee or his or her Dependent dies.

b) The Qualified Employee or a Dependent gains, or becomes, an eligible Dependent through marriage, birth, adoption, placement for adoption, or grant of court or testamentary guardianship or child support order (MCSO or QMSO) or other court order.

c) The Qualified Employee or a Dependent has a foster child placed by an accredited foster child agency. (Note: The foster child is not eligible for coverage.)

d) The Qualified Employee or his or her Dependent receives confirmation of pregnancy, by a certified licensed healthcare professional acting within the scope of the professional's practice.

The Special Enrollment period is effective as of the first of the month a health care professional certifies that the Qualified Employee or his or her Dependent is pregnant or effective on the first day of the month following the date that the Qualified Employee or his or her Dependent makes a plan selection.

e) The Qualified Employee's or Dependent's enrollment in another Qualified Health Plan or non-enrollment, as evaluated and determined by the SHOP Exchange, is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the SHOP Exchange or the United States Department of Health and Human Services or its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities.

f) The Qualified Employee or Dependent, who is an enrollee in another Qualified Health Plan, demonstrates to the SHOP Exchange that the other Qualified Health Plan in which he or she has enrolled substantially violated a material provision of its contract in relation to the Qualified Employee or Dependent.

g) The Qualified Employee or his or her Dependent gains access to new Qualified Health Plans as a result of a permanent move and either:

(1) had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the sixty (60) days preceding the date of the permanent move; or,

(2) was living in a foreign country or in a United States territory for one or more days during the sixty (60) days preceding the date of the permanent move.

h) The Qualified Employee is an Indian, as defined in section 4 of the Indian Health Care Improvement Act, who may enroll in a Qualified Health Plan or change coverage from one Qualified Health Plan to another one time per month or who is or becomes a Dependent of an Indian, as defined by section 4 of the Indian Health Care Improvement Act and is enrolled or is enrolling in a Qualified Health Plan through an Exchange on the same application as the Indian, may change from one Qualified Health Plan to another one time per month, at the same time as the Indian.

i) The Qualified Employee or Dependent demonstrates to the SHOP Exchange, in accordance with guidelines issued by the United States Department of Health and Human Services that he or she meets other exceptional circumstances determined by the SHOP Exchange .

j) The Qualified Employee or Dependent enrolled in the same Qualified Health Plan is determined to be newly eligible or newly ineligible for advance premium tax credit or has a change in eligibility for cost-sharing reductions

For purposes of this provision, advance premium tax credit means tax credits specified under section 1401 of the Affordable Care Act which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through the District of Columbia Health Benefit

Exchange. For purposes of this provision, cost-sharing reduction means an affordability program under Section 1402 of the Affordable Care Act.

k) The Qualified Employee or his or her Dependent:

(1) is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2T, as amended, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or,

(2) is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim.

l) The Qualified Employee or his or her Dependent:

(1) applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the SHOP Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than sixty (60) days after the qualifying event; or

(2) applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;

m) The Qualified Individual, or his or her Dependent, enrollment in the QHP through the Exchange was influenced by a material error related to plan benefits, Service Area, cost-sharing, or premium resulting in the eligible individual's decision to purchase a QHP through the Exchange. A material error is one that is likely to have influenced a Qualified Individual's, enrollee's, or his or her Dependent's enrollment in a QHP.

2. The Special Enrollment Period shall be as follows:

a) For the qualifying event listed in Section 2.5C.1.b) and c) (Qualified Employee or Dependent gains, or becomes, an eligible Dependent through marriage, birth, adoption, placement for adoption, placement for foster care, grant of court or testamentary guardianship), or child support order (MCSO or QMSO) or other court order: The thirty-one (31) day period from the date of the qualifying event.

b) If an eligible employee or Dependent meets the requirements for the triggering event described in 2.5C.1.d), the exchange may take any action necessary to correct or eliminate the effects of the error, misrepresentation, or inaction.

c) For the qualifying event listed in Section 2.5C.1.g) (Qualified Employee is an Indian, as defined in section 4 of the Indian Health Care Improvement Act): One time per month.

d) For all other qualifying events listed in Section 2.5C.1: The thirty (30) day period from the date of the qualifying event, unless otherwise determined by the SHOP Exchange.

3. Sixty (60) Day Special Enrollment Period. In addition, an eligible individual may enroll as a Subscriber or Dependent upon the occurrence of one of the following qualifying events:

   a) The Qualified Employee or Dependent loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a state child health plan under title XXI of the Social Security Act;

   b) The Qualified Employee or Dependent becomes eligible for assistance, with respect to coverage under a Qualified Health Plan offered through the SHOP Exchange, under such Medicaid plan or a state child health plan (including any waiver or demonstration project conducted under or in relation to such a plan); or

   c) The Qualified Employee or Dependent is enrolled in an employer-sponsored health benefit plan that is not qualifying coverage in an eligible employer sponsored plan and is allowed to terminate existing coverage.

4. With the exception of Section 2.5.C.3.c), the Special Enrollment Period for the qualifying events listed in Section 2.5C.3 shall be the sixty (60) day period from the date of the qualifying event. In the event of a qualifying event under Section 2.5.C.3.c), the Special Enrollment Period shall be sixty (60) days prior to the end of coverage under the employer sponsored plan.

5. A Dependent of a Qualified Employee is not eligible for a Special Enrollment Period if the Group does not extend coverage the offer of coverage to Dependents.

D. Effective Dates

1. The Effective Date for a Qualified Employee who enrolls during an Annual Open Enrollment Period shall be the first day of the new policy year, unless otherwise provided by the SHOP Exchange.

2. The Effective Date for a newly eligible Qualified Employee and any Dependent who timely enrolls as provided in Section 2.5B shall be as stated in the Eligibility Schedule.

3. The Effective Date for a Dependent Child who timely enrolls during a Special Enrollment Period is the Dependent Child's First Eligibility Date (unless otherwise provided by the SHOP Exchange).

   a) First Eligibility Date means:

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

      (2) For a non-newborn Dependent Child who is a stepchild, the date the stepchild became a Dependent of the Subscriber;

      (3) For a newly adopted Dependent Child, the earlier of;

         (a) A judicial decree of Adoption; or

         (b) Placement of the child in the Subscriber's home as the legally recognized proposed adoptive parent;

      (4) For a Dependent Child for whom guardianship of at least twelve (12) months' duration has been granted by court or testamentary appointment, the date of the appointment;

(5) For a Dependent Child who has been placed with the Subscriber through a child support order (MCSO or QMSO) or other court order, the date that the court order is effective;

(6) For all other Dependent Children, the first day of the month following the receipt of enrollment by the SHOP Exchange.

b) The Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the child's First Eligibility Date. The Subscriber must enroll such a Dependent Child within thirty-one (31) days of the child's First Eligibility Date when an additional premium is due for the enrollment of the Dependent Child. Otherwise, the Dependent Child will not be covered and cannot be enrolled until the next Annual Open Enrollment Period. (An additional premium will be due unless there are three (3) or more Dependent Children under the age of twenty-one (21) already enrolled by the Subscriber).

4. The Effective Date for a Qualified Employee or Dependent who gains, or becomes, an eligible Dependent through marriage and who timely enrolls during a Special Enrollment Period shall be the first day of the month following the receipt of enrollment by the SHOP Exchange.

5. The Effective Date for a Qualified Employee (and eligible Dependents) with whom a child was placed through a foster care program shall be the date that the child was placed with the Qualified Employee (and eligible Dependents) in foster care (unless otherwise provided by the SHOP Exchange). Note that foster children are not eligible for coverage.

6. The Effective Date for a Qualified Employee or Dependent who receives confirmation of pregnancy, by a certified licensed healthcare professional acting within the scope of the professional's practice, shall be the first of the month a health care professional certifies that the Qualified Employee or his or her Dependent is pregnant or effective on the first day of the month following the date that the Qualified Employee or his or her Dependent makes a plan selection.

7. The Effective Date for a Qualified Employee or Dependent who loses other coverage, or who gains access to new Qualified Heath plans due to a permanent move, who timely enrolls during a Special Enrollment Period shall be the first day of the month following the receipt of enrollment by the SHOP Exchange, or as stated in Section 2.5D.8. below, at the option of the SHOP Exchange.

8. The Effective Date for a Qualified Employee or Dependent who timely enrolls due to a qualifying event stated in Section 2.5C.1.d) (enrollment or non-enrollment was unintentional, inadvertent, or erroneous and is the result of an error by the SHOP Exchange or the United States Department of Health and Human Services), Section 2.5C.1.e) (a Qualified Health Plan substantially violated a material provision of its contract), Section 2.5C.1.h) (other exceptional circumstances as determined by the SHOP Exchange), Section 2.5C.1.k) (applies for a QHP during annual open enrollment, is assessed by the SHOP-Exchange as potentially eligible for Medicaid or CHIP and then determined ineligible or applied for Medicaid or CHIP during annual open enrollment and determined to be ineligible) and 2.5C.1.l) (demonstration to the Exchange that a material error related to plan benefits, service area, or premium influenced the individual's decision to purchase a QHP) shall be the appropriate date based on the circumstances of the Special Enrollment Period as determined by the Exchange.

9. If an enrollee or his or her Dependent dies as stated in 2.5C.1.a)(4), the Effective Date of coverage is the first day of the month following plan selection or

provided in Section 2.5D.9 of this provision as determined by the SHOP Exchange.

10. In all other cases, the Effective Date for a Qualified Employee or Dependent who timely enrolls during a Special Enrollment Period will be:

    a) For enrollment received by the SHOP Exchange between the first (1st) and the fifteenth (15th) day of the month, the first day of the following month; and

    b) For enrollment received by the SHOP Exchange between the sixteenth (16th) and the last day of the month, the first day of the second following month.

11. Premium changes resulting from the enrollment of a Subscriber or a Dependent during a Special Enrollment Period will be effective as of the Effective Date of the Subscriber's or the Dependent's enrollment.

2.6 Child Support Orders (MCSO or QMSO).

A. Eligibility and Termination.

1. Upon receipt of an MCSO or QMSO, CareFirst will accept enrollment of a Dependent Child that is the subject of an MCSO or QMSO and the Qualified Employee parent of such child, without regard to enrollment period restrictions, within the time period prescribed by law. Coverage will be effective as of the effective date of the order, and the premium will be adjusted as needed. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any state or the District of Columbia. If the Subscriber is subject to a Waiting Period, the child will not be enrolled until the end of the waiting period.

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

    a) Was born out of wedlock;

    b) Is not claimed as a dependent on the Subscriber's federal tax return;

    c) Does not reside with the Subscriber; or

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

3. Coverage required by an MCSO or QMSO will be effective as of the date of the order.

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

    a) The MCSO or 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 members' coverage for all its employees; or

    d) The employer no longer employs the insuring parent, except if the parent elects to exercise the provisions of the Consolidated Omnibus Budget

Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the Group's plan for postemployment health insurance coverage for Dependents.

B. Administration. When the child subject to an MCSO or QMSO does not reside with the Subscriber, CareFirst will:

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

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:

a) The non-insuring parent;

b) The provider of the Covered Services, Covered Dental Services or Covered Vision Services; or

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

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

2.8 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 and the SHOP Exchange, including providing CareFirst and the SHOP Exchange with reasonable access to Group records upon request. At any time coverage under this Evidence of Coverage is in effect, CareFirst reserves the right to request documentation substantiating eligibility as described in this Evidence of Coverage and to provide any information it receives regarding a Member's eligibility to the Group or the SHOP Exchange.

2.9 Proof of Eligibility. CareFirst retains the right to require proof of relationships or facts to establish eligibility. CareFirst will pay the reasonable cost of providing such proof.

SECTION 3
TERMINATION OF COVERAGE

3.1 Termination of Enrollment by the Subscriber.

A. In the manner permitted by the SHOP Exchange, the Subscriber may terminate his or her enrollment, or (except as provided in Section 3.5) the enrollment of a Dependent, during the Annual Open Enrollment Period by notifying the Group or the SHOP Exchange. Upon termination of the Subscriber's enrollment, the enrollment of all enrolled Dependents will also be terminated.

B. Termination of Enrollment by the Subscriber Due to Qualifying Events.

1. If certain life events occur, a Subscriber may be able to make a mid-year change to reduce and/or terminate the coverage of the Subscriber or Dependent. The following is a list of qualifying life events that allow the Subscriber to reduce or terminate coverage. The changes in coverage must satisfy the consistency requirements as described below.

a) Qualifying Life Events:

(1) Legal marital status. A change in a Member's legal marital status, including marriage, divorce, death of spouse, a legal separation or an annulment.

(2) Domestic Partnership status. At the group administrator's discretion, a change in status of a Subscriber's Domestic Partnership status, including establishment or termination of a Domestic Partnership or death of the Subscriber's Domestic Partner.

(3) Employment status. A change in a Subscriber's, Spouse's or Dependent's employment status due to termination or commencement of employment, a strike or lockout, an unpaid leave of absence, or a change in worksite.

(4) Dependent status. A change in status of a Dependent that results in the Dependent's eligibility or ineligibility for coverage because of age or similar circumstances.

(5) Any of the qualifying events listed in Section 2.5C of the Evidence of Coverage, not otherwise specified in this provision.

(6) Any reduction or termination that a Subscriber makes must be consistent with the life event. The life event must affect eligibility for coverage under the plan or under a plan of the spouse or Dependent, which covers the spouse or Dependent as a Subscriber. The change in coverage must correspond with the life event.

2. Under certain circumstances, a Subscriber may make mid-year reduction or termination to coverage for reasons, such as coverage cost or Medicare eligibility as described below.

a) Coverage Events:

(1) If there is reduction or elimination of coverage during the Benefit Period.

(2) If the Spouse has a cafeteria plan which allows a Subscriber and Dependents to make an enrollment change during that plan's annual open enrollment period, the Subscriber may make a corresponding mid-year change.

b) Cost Events: If the cost of coverage increases or decreases significantly during a Benefit Period (including a Subscriber's change from part-time to full-time work or vice versa) and the Group does not offer a similar, but less costly, coverage option.

c) Entitlement to Medicaid, the federal child health insurance plan (CHIP) or a State-funded low-income basic health plan (known as a BHP). If a Subscriber or Dependent becomes eligible for Medicaid, the federal child health insurance plan (CHIP) or a State-funded low-income basic health plan (known as a BHP) mid-year, a Subscriber or Dependent *may* (but is not required) terminate coverage.

C. The effective date of the termination will be as follows:

1. On the date stated by the Subscriber, if the Subscriber has given reasonable notice. For purposes of this provision, reasonable notice is defined as fourteen (14) days from the requested termination date.

2. Fourteen (14) days after the date the Subscriber requested termination if the Subscriber does not provide reasonable notice.

3. If the Subscriber and Dependents give notice of termination of enrollment in order to enroll in another Qualified Health Plan, the day before the effective date of coverage under the new Qualified Health Plan.

4. If the Subscriber and Dependents are newly eligible for Medicaid, the federal child health insurance plan (CHIP) or a State-funded low-income basic health plan (known as a BHP), the day before coverage under one of these programs begins.

5. If the Subscriber terminates enrollment during an Annual Open Enrollment Period, on the last day of the Benefit Period.

3.2 Termination of Individual Enrollment by the CareFirst or the SHOP Exchange. CareFirst or the SHOP Exchange may terminate the coverage of a Subscriber and/or a Dependent at any time by written notice delivered or mailed to the last address as shown by the records of CareFirst or the SHOP Exchange under the following circumstances by providing the Subscriber at least thirty (30) days' notice prior to the last day of coverage:

A. Termination of Individual Enrollment for Ineligibility:

1. The Subscriber is no longer eligible for coverage for any reason. In this circumstance, the enrollment of the Subscriber and any Dependents will be terminated.

2. A Dependent is no longer eligible for coverage as a Dependent due to a change in the Dependent's age, status or relationship to the Subscriber, or no longer meets the eligibility requirements established by the Group.

3. The date of termination is stated in the Eligibility Schedule.

4. The Subscriber is responsible for notifying the SHOP Exchange of any changes in the status of a Dependent as an eligible individual; or his or her eligibility for coverage, except when the Dependent Child reaches the Limiting Age. These changes include a divorce and the marriage of a Dependent Child. If the Subscriber knows of a Dependent's ineligibility for coverage and intentionally fails to notify the SHOP Exchange of these types of changes, CareFirst has the right to seek Rescission of the coverage of the Dependent under Section 3.3 as of the initial date of the Dependent's ineligibility and recover the full value of the services and benefits provided during the period of Dependent's ineligibility. CareFirst can recover these amounts from the Subscriber and/or from the Dependent, less the premium paid during the period of ineligibility, at the option of CareFirst.

B. Termination of Group Contract due to the Decertification of the Evidence of Coverage as a Qualified Health Plan. If this Evidence of Coverage is Decertified as a Qualified Health Plan, the date of termination shall be the date established by the SHOP Exchange after written notice has been provided to the Subscriber and the Subscriber has been afforded an opportunity to enroll in other coverage.

C. Accommodation for Persons with Disabilities. Notwithstanding the termination provisions above, CareFirst, when required by the SHOP Exchange, shall make reasonable accommodation of these provisions for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating the coverage of such individuals.

3.3 Rescission of Individual Enrollment for Fraud or Misrepresentation. Coverage of a Member may be Rescinded if:

A. The Member has performed an act, practice, or omission that constitutes fraud;

B. The Member has made an intentional misrepresentation of material fact; or

C. An act, practice or omission that constitutes fraud includes, but is not limited to, fraudulent use of CareFirst's identification card by the Member, the alteration or sale of prescriptions by the Member, or an attempt by a Subscriber to enroll non-eligible persons.

D. CareFirst demonstrates, to the reasonable satisfaction of the SHOP Exchange, if required by the SHOP Exchange, that the rescission is appropriate.

CareFirst will provide thirty (30) days advance written notice of any Rescission. CareFirst shall have the burden of persuasion that its Rescission complies with applicable local law. The Rescission shall either (i) void the enrollment of the Member as of the Member's Effective Date (for fraudulent acts, practices, or omissions that occur at the time of enrollment); or (ii) in all other cases, void the enrollment of the Member as of the first date the Member performed an act, practice or omission which constituted fraud or made an intentional misrepresentation of material fact. The Subscriber will be responsible for payment of any voided benefits paid by CareFirst, net of applicable premiums paid.

3.4 Death of Subscriber. In the event of the Subscriber's death, coverage of any Dependents may continue under the Subscriber's enrollment as stated in this Evidence of Coverage. The date of termination of the Subscriber's enrollment and, if applicable, the enrollment of any Dependents will be as stated in the Eligibility Schedule.

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

3.6 Termination of Evidence of Coverage upon Termination of Group Contract. This Evidence of Coverage, and the enrollment of the Member(s), will terminate automatically upon the date of the termination of the Group Contract by the Group, the SHOP Exchange or CareFirst for any reason.

3.7 Effect of Termination. 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 date of termination.

3.8 No Reinstatement. Upon termination, enrollment will not reinstate automatically under any circumstances.

SECTION 4
CONTINUATION OF COVERAGE

4.1 Continuation of Eligibility upon Loss of Group Coverage.

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

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

If an eligible employee leaves his or her job to perform military service, the eligible employee has the right to elect to continue his or her 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 eligible employee's military service, the eligible employee has the right to be reinstated in their Group coverage when re-employed, without any Waiting Periods or pre-existing condition exclusion periods except for service connected illnesses or injuries. If an eligible employee has any questions regarding USERRA, the eligible employee should contact the plan administrator. The plan administrator determines eligible employees and provides the information to CareFirst.

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

A. The Subscriber and any Dependents have the right to continue coverage under the Group Contract for a period of three (3) months, or for the period of time during which the Subscriber is eligible for premium assistance under the American Recovery and Reinvestment Act of 2009, as amended, unless:

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

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

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

B. Duties of the Group.

1. The Group shall furnish Subscribers whose coverage terminates with written notification of the Subscriber's eligibility to continue coverage under DCCHC. Such notice shall be furnished no later than fifteen (15) days of the date coverage under this Evidence of Coverage would otherwise terminate. Failure by the Group to furnish the required notification shall not extend the right to continue coverage beyond the three-month period, or for the period of time during which the Subscriber is eligible for premium assistance under the American Recovery and Reinvestment Act of 2009, as amended.

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

C. Duties of the Subscriber.

1. Individuals who elect coverage under this Section shall bear the cost of the continued coverage and such cost shall not exceed one hundred two percent (102%) of the Group's rate.

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

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

1. The Member establishes residence outside CareFirst Service Area;

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

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

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

5. The Member becomes entitled to Medicare; or

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

E. Reinstatement
If any renewal premium be not paid within the time granted the group for payment, a subsequent acceptance of premium by CareFirst, without requiring in connection therewith an application for reinstatement, shall reinstate this Policy. Losses during the period of reinstatement shall cover only loss resulting from the benefits listed in the policy as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date If CareFirst, requires a new application for reinstatement and subsequently issues a conditional receipt for the premium tendered, this Policy may be reinstated upon approval by DISB of such new application, and lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt. If any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

4.3 Right to Continue Coverage Under Only One Provision. If a Member is eligible to continue coverage under the Group Contract under more than one continuation provision as described above, the Member will receive only one such continuation coverage. The Group will select the continuation option the member will receive.

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 reviewed first. Those rules determine whether the benefits of this CareFirst BlueChoice Plan are determined before or after those of another Plan. The benefits of this CareFirst BlueChoice Plan:

   a) Shall not be coordinated when, under the order of determination rules, this CareFirst BlueChoice Plan determines its benefits before another Plan ;

   b) May be coordinated when, under the order of determination rules, another Plan determines its benefits first. The coordination is explained in Section 5.1D.2.

3. This policy's Coordination of Benefits provisions do not apply to claims for services rendered to a newly born child within 0 to 31 days of the child's date of birth until both (all) plans have processed and paid the claims for the newborn coverage period (0 to 31 days). After such payments have been made, this policy's Coordination of Benefits provisions will be used to determine which plan is primary and which plan is secondary.

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

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments that are covered in whole or in part by any of the Plans covering the Member. This means any expense or portion of an expense 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.

Dental Plan means any dental insurance policy, including those of nonprofit health service plans, and those of commercial group, blanket, and individual policies, any subscriber contracts issued by Health Maintenance Organizations (HMOs), and any other established programs under which the insured may make a claim. The term Dental Plan includes coverage under a governmental plan, or coverage required to be 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.)

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

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

The term Plan does not include:

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

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

3. Coverage regulated by a motor vehicle reparation law;

4. The first one-hundred dollars ($100) per day of a hospital indemnity contract; 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 stating whether this CareFirst Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

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

2. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be coordinated 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 specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease specified in the policy or for treatment unique to a specified disease.

C. Order of Benefit Determination Rules.

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

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

   b) Both those rules and this CareFirst Plan's rules require 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 if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

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

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

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

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

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

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

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

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

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

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

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

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

ii) The Plan of the Spouse of the parent with the custody of the child;

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

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

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

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

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

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

(2) Second, the benefits under the continuation coverage.

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

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

f) Medical and Dental Plan. When a Member has coverage under two Plans, and one of the Plans is a medical plan and the other is a Dental Plan, and a determination cannot be made in accordance with the order of benefit determination rules in this CareFirst Plan, the medical plan should be considered as the Primary Plan.

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 such an event, the benefits of this CareFirst Plan may be coordinated under this section. Any additional other Plan or Plans are referred to as "the other Plans" immediately below.

2. Coordination in this CareFirst Plan's Benefits. When this CareFirst Plan is the Secondary Plan, the benefits under this CareFirst Plan *may* be coordinated so that the total benefits 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 coordinated, each benefit is coordinated 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 the amount to the organization that made that payment. The amount will then be treated as though it were a benefit paid under this CareFirst Plan. This CareFirst Plan will not have to pay the 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 is more than it should have paid under this COB provision, it may recover the excess from one or more of:

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

2. Insurance companies; or

3. Other organizations.

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

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

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

B. Medicare as Primary.

When benefits for Covered Services, Covered Dental Services or Covered Vision Services are paid by Medicare as primary, this CareFirst Plan will not duplicate those payments. CareFirst will coordinate and pay benefits based on Medicare's payment (or the payment Medicare would have paid). When CareFirst coordinates the benefits with Medicare, CareFirst's payments will be based on the Medicare allowance (if the provider is a participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare), less any claim reduction or denial due to a Member's failure to comply with Medicare's administrative requirements. CareFirst's right to coordinate is not contingent on any payment actually being made on the claim by Medicare. Members enrolled in Medicare agree to, and shall, complete and submit to Medicare, CareFirst, and/or any health care providers all claims, consents, releases, assignments and other documents required to obtain or assure such claim payment by Medicare.

If a Medicare-eligible Member has not enrolled in Medicare Part A and/or Part B, CareFirst will not "carve-out," coordinate, or reject a claim based on the amount Medicare would have paid had the Member actually applied for, claimed, or received Medicare benefits.

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

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

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

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

5.4 Subrogation

A. CareFirst has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. Subrogation applies to any illness or injury which is:

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

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

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

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

All recoveries the Member or the Member's representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated (for example as "pain and suffering"), must be used to reimburse CareFirst in full for benefits paid. CareFirst's share of any recovery extends only to the amount of benefits paid or payable to the Member, the Member's representatives, and/or health care providers on the Member's behalf. For purposes of this provision, "Member's representatives" include, if applicable, heirs, administrators, legal representatives, parents (if the Member is a minor), successors, or assignees. This is CareFirst's right of recovery.

C. CareFirst's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. If required by law, CareFirst will reduce the amount owed by the Member to CareFirst in accordance with applicable law.

D. CareFirst will have a lien on all funds the Member recovers up to the total amount of benefits provided. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. CareFirst may give notice of that lien to any party who may

have contributed to the Member's loss, or who may be liable for payment as a result of that loss.

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

F. Members agree to take action, furnish information and assistance, and execute such instruments that CareFirst may require while enforcing CareFirst rights under this Section. The Member agrees to not take any action which prejudices CareFirst's rights and interests under this provision.

SECTION 6
GENERAL PROVISIONS

6.1 Entire Certificate; Changes. The entire Evidence of Coverage includes: (a) this Evidence of Coverage; (b) Benefit Determinations and Appeals; (c) the Description of Covered Services; (d) Schedule of Benefits; (e) Eligibility Schedule; and (f) any additional duly authorized notices, amendments and riders.

No amendment or modification of any term or provision of this Evidence of Coverage is effective unless authorized in writing by an executive officer of CareFirst. Any duly authorized notice, amendment or rider will be issued by CareFirst to be attached to the Evidence of Coverage. No agent has authority to change this agreement or to waive any of its provisions. Any waiver of an Evidence of Coverage term or provision shall only be given effect for its stated purpose and shall not constitute or imply any subsequent waiver.

Oral statements cannot be relied upon to modify or otherwise affect the benefits, limitations and/or exclusions of this Evidence of Coverage, or increase or void any coverage or reduce any benefits. Such oral statements cannot be used in the prosecution or defense of a claim.

6.2 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 the non-insuring, custodial parent identification cards, claims forms, the applicable certificate of coverage or member contract, and any information needed to obtain benefits;

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:

   a) The non-insuring, custodial parent;

   b) The provider of the Covered Services, Covered Dental Services, or Covered Vision Services; or

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

B. Proof of Loss. For Covered Services provided by Preferred Providers, Preferred and Participating Dentists, Contracting Vision Providers, and Contracting Pharmacies, Members are not required to submit claims in order to obtain benefits.

For Covered Services provided by Non-Preferred Providers, Non-Participating Dentists, Non-Contracting Vision Providers, and Non-Contracting Pharmacies, Members must furnish written proof of loss, or have the provider submit proof of loss, to CareFirst within one (1) year after the date of the loss.

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

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

C. Time of Payment of Claims. Benefits payable will be paid immediately after receipt of written proof of loss.

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

E. Payment of Claims. Payments for Covered Services will be made by CareFirst directly to Contracting Vision Providers, Participating and Preferred Dentists and Preferred Providers. Direct payments will also be made by CareFirst to providers from the United States Department of Defense and the United States Department of Veteran Affairs. If a Member receives Covered Services from Non-Contracting Vision or Non-Preferred or Non-Participating Providers, CareFirst reserves the right to pay either the Member or the provider. If the Member has paid the health care provider for services rendered, benefits will be payable to the Member. The payment will, in either case, be full and complete satisfaction of CareFirst's obligation, unless an appeal or grievance has been filed by, or on behalf of, the Member. Benefits will be paid to the Member, if living, or to the Member's beneficiary. If there is no living beneficiary, benefits are payable to the Member's estate. CareFirst may pay up to $1,000 to any relative of the Member who CareFirst finds is entitled to it. Any payment made in good faith will fully discharge CareFirst to the extent of the payment.

6.3 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 applicable law.

6.4 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 written proof of loss is required to be submitted to CareFirst.

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, 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 law.

6.6 Physical Examinations and Autopsy. CareFirst, at its own expense, has the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

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

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

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

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

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

6.9 Member Privacy. CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable financial, medical or health related data. In that regard, CareFirst will not provide to unauthorized third parties any personally identifiable financial or medical information without the prior written authorization of the Member or parent/guardian of the Member or as otherwise permitted by law. Personal information, including email addresses and phone numbers, may be used and shared with other businesses who work with CareFirst to administer and/or provide benefits under this plan. Personal information, as described below, may also be used to notify enrollees about treatment options, health-related services, and/or coverage options. Enrollees may contact CareFirst to change the information used to communicate with them.

The more complete information health care providers have, the better they can meet the Members' health care needs. Sharing information and data with the Member's treating providers can lead to better coordinated care, help the Member get timely care, limit duplicative services, and help the provider better identify patients who would benefit most from care management and other care coordination programs.

How we use medical information to enhance or coordinate the Member's care — In order to administer the Member's health benefits, CareFirst receives claims data and other information from the Member's various providers of care regarding diagnoses, treatments, programs and services provided under your health plan. Individual treating providers, however, may not have access to information from the Member's other providers. When CareFirst has such information, it may share it with the Member's treating providers through secure, electronic means solely for purposes of enhancing or coordinating the Member's care and to assist in clinical decision making.

The Member may Opt-Out of information sharing by CareFirst for these care coordination purposes. The Member has the right to opt-out of the sharing of this information by CareFirst with his/her treating provider for care coordination purposes at any time. To opt-out, the Member must complete, sign and return the *Opt-Out of Medical Information Sharing* Form found at www.carefirst.com/informationsharing. **When the Member submits this form, the Member also ends participation in any of the programs listed in this Agreement that require the sharing of information to enhance or coordinate care. If the Member opts out, his/her treating providers will not have access to the data or information CareFirst has available to help enhance or coordinate his/her care.**

6.10 Relationship of CareFirst to Health Care Providers. Health care providers, including Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers, are independent contractors or organizations and are related to CareFirst by contract only. Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers are not employees or agents of CareFirst and are not authorized to act on behalf of or obligate CareFirst with regard to interpretation of the terms of the Evidence of Coverage, including eligibility of Members for coverage or entitlement to benefits. Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy 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 Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, Contracting Pharmacy Providers, or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

6.11 Provider and Services Information. Listings of current Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers will be made available to Members at the time of enrollment. Updated listings are available to Members upon request. The listing of Preferred Providers, Preferred Dentists and Contracting Vision Providers is updated every fifteen (15) days on the CareFirst website (www.carefirst.com).

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

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

6.14 Delivery of Evidence of Coverage. Unless CareFirst makes delivery directly to the Member, CareFirst will provide to the Group, for delivery to each Subscriber, 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 an MCSO/QMSO. In this instance, an additional Evidence of Coverage will be delivered to the custodial parent upon request.

6.15 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.

6.16 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 the SHOP Exchange the premium as specified in the Group Contract for all Members.

6.17 Rights under Federal Laws. The Group may be subject to federal law (including the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and/or the Affordable Care Act) 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, HIPAA and/or the Affordable Care Act, as applicable.

6.18 Representations and not Warranties. All statements made by the Subscriber shall be deemed to be representations and not warranties. No statement made for the purpose of obtaining coverage shall void such coverage or reduce benefits unless contained in a written instrument signed by the Subscriber, a copy of which has been furnished to CareFirst.

6.19 Rules for Determining Dates and Times. The following rules will be used when determining dates and times:

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

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

6.20 Notices.

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

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

Group Hospitalization and Medical Services, Inc.
1440 G Street, NW
Washington, DC 20005

1. 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.

2. CareFirst may change the address at which notice is to be given by giving written notice thereof to the Subscriber.

6.21 Amendment Procedure. Amendments must be consistent with federal and state law. CareFirst may amend the Evidence of Coverage with respect to any matter by the means and within the time frame allowed by the procedures established by the SHOP Exchange.

A. CareFirst will give notice of any amendment at least sixty (60) days before the effective date that coverage will be renewed. If a material modification required to conform the Evidence of Coverage to changes in applicable state or federal law is made at a time other than renewal and it affects the content of the summary of benefits and coverage, CareFirst will provide at least sixty (60) days advanced notice of the modification.

Regardless of when the amendment is received, the Evidence of Coverage is considered to be automatically amended as of the date specified in the contract amendment or the notice (if not stated in the contract amendment), unless otherwise mandated to conform with any applicable changes to state or federal law.

B. No agent or other person, except an officer of CareFirst, has authority to waive any conditions or restrictions of the Evidence of Coverage, or to bind CareFirst by making any promise or representation or by giving or receiving any information. No change in the Evidence of Coverage will be binding on CareFirst, unless evidenced by an amendment signed by an authorized representative of CareFirst.

6.22 Regulation of CareFirst. CareFirst is subject to regulation in the District of Columbia by the Department of Insurance, Securities and Banking pursuant to Title 31 of the District of Columbia Code and the District of Columbia Department of Health pursuant to Reorganization Plan No. 4 of 1996, as amended.

6.23 Conformity to Law. Any provision in this Evidence of Coverage that is in conflict with the requirements of any state or federal law that applies to this Evidence of Coverage is automatically changed to satisfy the minimum requirements of such law.

6.24 Selection of a Primary Care Physician. Consultation and visits with a Primary Care Physician are required to be able to satisfy the requirements of the Wellness Credit Section as stated in the Description of Covered Services.

A. For a Member in the CareFirst Service Area. A Member may identify any Primary Care Physician from CareFirst's current list of Preferred Providers. If the Primary Care Physician is not available, CareFirst will assist the Member in identifying another selection.

B. For a Member outside the CareFirst Service Area. The Member must consult and visit a Primary Care Physician who is a BlueCard PPO Network Provider as defined in the Inter-Plan Arrangements Disclosure Amendment.

6.25 Credit Monitoring. CareFirst is offering credit monitoring to the Subscriber and eligible Dependents at no additional charge through services administered by Experian. Credit monitoring is available on an opt-in basis for all eligible Members during the effective Benefit Period of their CareFirst health insurance policy. Eligible Members may enroll by calling the number on their ID card or visiting www.carefirst.com.

6.26 Surprise Medical Bills. For information about your rights and protections against surprise medical bills, please visit the following site: https://individual.carefirst.com/individuals-families/mandates-policies/balance-billing.page.

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
1440 G Street, NW
Washington, DC 20005
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT A

BENEFIT DETERMINATIONS AND APPEALS

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

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

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

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

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A. DEFINITIONS

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

1. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in this plan. An Adverse Benefit Determination includes a Rescission.

2. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Cosmetic, Experimental or Investigational, or not Medically Necessary or appropriate.

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

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

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

Rescission means, as used in this attachment, a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions towards the cost of coverage.

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

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

2. In the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

B. BENEFIT DETERMINATIONS

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

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

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

   If a Member fails to provide sufficient information for CareFirst to determine whether benefits are covered or payable, CareFirst will notify the Member as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claims. The Member shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. CareFirst will notify the Member of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

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

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

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

   This period may be extended one time by CareFirst for up to 15 days, provided that such an extension is necessary due to matters beyond the control of CareFirst and CareFirst notifies the Member, prior to the expiration of the initial 15-day period, of

the circumstances requiring the extension of time and the date by which CareFirst expects to render a decision. If such an extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Member will have at least 45 days from receipt of the notice within which to provide the specified information.

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

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

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

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

3. Post-Service Claims. In the case of a Post-Service Claim, CareFirst shall notify the Member of the CareFirst's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by CareFirst for up to 15 days, provided that CareFirst both determines that such an extension is necessary due to matters beyond the control of CareFirst and notifies the Member, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which CareFirst expects to render a decision. If such an extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

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

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

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

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

6. Calculating Time Periods. For purposes of this Part B, the period of time within which an Adverse Benefit Determination is required to be made shall begin at the time a claim is filed in accordance with CareFirst procedures. The time is counted regardless to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a Member's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information.

7. In the case of an Adverse Decision, CareFirst shall send the Member, the Member's Representative or Health Care Provider acting on behalf of the Member written or electronic notification of any Adverse Benefit Determination.

C. INTERNAL GRIEVANCE PROCEDURE

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

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

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

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

5. A Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's claim for benefits. A document, record, or other information shall be considered relevant to a Member's claim if it:

   a. Was relied upon in making the benefit determination;

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

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

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

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

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

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

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

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

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

b. notifies the Member, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which CareFirst expects to render a decision.

If such an extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

In the event that a period of time is extended due to a Member's failure to submit necessary information, the period for responding to a grievance shall be tolled from the date on which the notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information.

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

D. FAIR AND FULL REVIEW

CareFirst will provide a review that:

1. Takes into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

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

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

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

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

E. DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEAL PROCESS

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

F. EXTERNAL APPEAL PROCEDURE

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

If a Member is dissatisfied with the resolution reached through CareFirst's internal grievance system regarding medical necessity, the Member may contact the Director at the following:

Director, District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th St. N.W., Suite 250 North
Washington, D.C. 20001
1 (877) 685-6391, (202) 724-7491
Fax: (202) 442- 6724

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

Commissioner, Department of Insurance, Securities and Banking
1050 First St. N.E. Suite 801
Washington, D.C. 20002
(202) 727-8000
Fax: (202) 354-1085

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

Group Hospitalization and Medical Services, Inc.

[Signature]

[Name]
[Title]

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
1440 G Street, NW
Washington, DC 20005
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT B

DESCRIPTION OF COVERED SERVICES

The services described herein are eligible for coverage under the Evidence of Coverage. CareFirst will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services incurred by a Member.

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 Maximum, and other features that affect Member coverage, including specific benefit limitations.

Refer to the Evidence of Coverage for additional definitions of capitalized terms included in this Description of Covered Services.

Group Hospitalization and Medical Services, Inc.

[Signature]

_____

[Name]
[Title]

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SECTION 1
OUTPATIENT FACILITY, OFFICE, AND PROFESSIONAL SERVICES

See the Prior Authorization Amendment for Covered Services that may require prior authorization

1.1 Office Visits

A. Benefits are available for office visits for the diagnosis and treatment of a medical condition, including care and consultation provided by primary care providers and Specialists.

B. Selected Providers

1. Definitions

Virtual Care means the use of digital technology interaction for the purpose of consultation, diagnosis, management, and/or treatment of the patient.

Virtual Connect Providers means a provider who contracts with CareFirst BlueChoice and is selected to provide preventive services, PCP office visit services, mental health/Substance Use Disorder services, and Virtual Care office visit services to Members.

Selected Provider means a provider who contracts with CareFirst BlueChoice and is selected to provide preventive services, PCP office visit services, and mental health/Substance Use Disorder office visit services in person or via Virtual Care to Members.

2. Covered Services

a) Benefits are provided for Medically Necessary care by a Selected Provider.

b) For Covered Services with visit limitations, these visit limitations will apply to the Selected Provider(s).

c) To learn more about the Selected Providers and how to access care, please visit www.carefirst.com/virtualconnect program.

1.2 Laboratory Tests, X-Ray/Radiology Services, Specialty Imaging, and Diagnostic Procedures
Coverage is provided for laboratory and pathology services, x-ray/radiology services, specialty imaging, and diagnostic procedures. Covered services include mammograms, ultrasounds, nuclear medicine, CAT Scans, MRIs, EKGs, EEGs, MRAs, MRSs, CTAs, PET scans, SPECT scans, nuclear cardiology, and related professional services for lab interpretation, x-ray reading, and scan reading.

A. For purposes of this provision, specialty imaging includes MRIs, MRAs and MRSs, PET scans, CAT scans and nuclear medicine studies.

B. Sleep Studies.

1. Coverage is provided for electro-diagnostic tests used to diagnose sleep disorders, including obstructive sleep apnea. These tests may also be used to help adjust a treatment plan for a sleep disorder that has been previously diagnosed. These tests may be done at home, freestanding facilities, outpatient hospital facilities, or at a sleep disorder unit within a hospital.

2. Prior authorization is required for facility-based sleep tests, independent sleep clinic services, and inpatient sleep tests. Prior authorization is not required for home sleep tests.

1.3 Preventive Services

In addition to the benefits listed in this provision, CareFirst will provide benefits for health exams and other services for the prevention and detection of disease, at intervals appropriate to the Member's age, sex, and health status, in accordance with the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended, as well as CareFirst preventive guidelines. At a minimum, benefits for preventive services listed in this provision will be provided once per Benefit Period.

Benefits will be provided for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). This includes benefits for preventive maternity care. CareFirst will update new recommendations to the preventive benefits listed in this provision at the schedule established by the Secretary of Health and Human Services.

Benefits for preventive care include the following:

A. Cancer Screening Services Benefits include:

1. Prostate Cancer Screening
Benefits are available when rendered in accordance with the most current National Comprehensive Cancer Network's guidelines and include a medically recognized diagnostic examination, an annual digital rectal examination, and the at least one prostate-specific antigen (PSA) test.

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

3. Pap Smears
Benefits are available for pap smears, including tests performed using FDA approved gynecological cytology screening technologies, at intervals appropriate to the Member's age and health status, as determined by CareFirst.

4. Breast Cancer Screening. Benefits will be provided for:

a) At a minimum, breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.

b) A baseline mammogram for women, including a 3-D mammogram.

c) An annual screening mammogram for women, including a 3-D mammogram.

d) Adjuvant breast cancer screening, including magnetic resonance imaging, ultrasound screening, or molecular breast imaging of the breast if:

1) A woman is believed to be at an increased risk for cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications of an increased risk for cancer as determined by a woman's physician or advanced practice registered nurse; or

2) A mammogram demonstrates a Class C or Class D Breast Density Classification.

Breast Density Classification means the four levels of breast density identified by the Breast Imaging Reporting and Data System established by the American College of Radiology.

B. Human Papillomavirus Screening Test

1. Coverage is provided for a Human Papillomavirus Screening Test at the screening intervals supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

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

C. Immunizations

Coverage is provided for immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. Immunizations required solely for travel or work are not covered.

A recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered to be:

1. In effect after it has been adopted by the Director of the Centers for Disease Control and Prevention; and

2. For routine use if it is listed on the immunization schedules of the Centers for Disease Control and Prevention.

D. Well Child Care

With respect to infants, children, and adolescents, coverage is provided for evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

E. Adult Preventive Care

Benefits include health care services incidental to and rendered during an annual visit at intervals appropriate to the Member’s age, sex, and health status, including evidence- based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).

F. Preventive Gynecological Care

Benefits include recommended preventive services that are age and developmentally appropriate as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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

1. Well child care visits for obesity evaluation and management;

2. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF);

3. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and,

4. Office visits for the treatment of obesity.

H. 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.

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

1.5 Family Planning Services Benefits will be provided for:

A. Non-Preventive Gynecological Care
Benefits are available for Medically Necessary gynecological care. Benefits for preventive gynecological care are described in Section 1.3.F.

B. Contraceptive Methods and Counseling Covered Benefits:

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

2. Benefits will be provided for all FDA approved contraceptive drugs and devices for all Members, and sterilization procedures (includes consultations and follow-up visit) and other contraceptive methods for female Members that must be administered to the Member in the course of a covered outpatient or inpatient treatment.

3. Coverage will be provided for the insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs that are approved by the FDA.

4. Voluntary sterilization for male Members (includes consultations and follow-up visit) and surgical reversal of voluntary sterilization for all members.

5. Abortion Care. Coverage will be provided for abortion care services. There is no Deductible, Copayment or Coinsurance for abortion care. Except for Health Savings Account (HSA)-compatible plans to which the Member has contributed to his/her HSA during the Benefit Period, the Deductible, if any, does not apply to abortion care.

   See Section 10, Prescription Drugs, for coverage for self-administered FDA-approved contraceptive drugs and devices.

C. Doula Services

A certified doula, or birth worker, is a trained professional authorized under state law to provide physical, emotional, and informational support to birthing people under this section. This support can happen before, during, and after birth. Certified doulas serving Members will provide person-centered care that supports their racial, ethnic, and cultural diversity. Certified doulas are non-clinical providers, and cannot perform the work of a nurse-midwife, nurse practitioner or doctor.

Benefits are limited to twelve (12) visits per Benefit Period for certified doulas. The visit limit is combined In-Network and Out of Network.

There is no In-Network Deductible, Copayment and/or Coinsurance associated with doula services. For Health Savings Account (HSA)-compatible plans, the In-Network Deductible applies to non-preventive services provided under this provision. For Out-of-Network services, the Out-of-Network Deductible applies and there is no Copayment or Coinsurance.

D. Maternity Services

The following maternity services are provided for all female members.

1. Preventive Services

   a) Routine outpatient obstetrical care of an uncomplicated pregnancy, including prenatal evaluation and management office visits and one post- partum office visit;

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

   c) Preventive laboratory tests and services rendered to a newborn during a covered hospitalization for delivery, identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B,” the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, including the collection of adequate samples for hereditary and metabolic newborn screening and newborn hearing screening; and

   d) Breastfeeding support, supplies, and consultation.

2. Non-Preventive Services

a) Outpatient obstetrical care and professional services for all prenatal and post-partum complications. Services include prenatal and post-partum office visits and ancillary services provided during those visits, such as Medically Necessary laboratory tests and diagnostic services;

b) Inpatient care for delivery;

c) Non-preventive routine professional services rendered to the newborn during a covered hospitalization for delivery. A newborn Dependent child will be automatically covered for the first thirty-one (31) days following the child's birth. The Evidence of Coverage describes the steps, if any, necessary to enroll a newborn Dependent child.

3. In a group-based prenatal care model, facilitators support a cohort of eight to ten birthing people of similar gestational age. These visits consist of discussion sessions covering medical and non-medical aspects of pregnancy, including nutrition, common discomforts, stress management, labor and birth, breastfeeding, and infant care.

There are no visit limits for group prenatal care.

There is no In-Network Deductible, Copayment and/or Coinsurance associated with group prenatal care. For Health Savings Account (HSA)-compatible plans, the In-Network Deductible applies to non-preventive services provided under this provision. For Out-of-Network services, the Out-of-Network Deductible applies and there is no Copayment or Coinsurance.

4. Postpartum Home Visits. See Section 6.3.C., Home Health Care Services.

E. Newborn Coverage. Coverage includes:

1. Medically Necessary routine newborn visits including admission and discharge exams and visits for the collection of adequate samples for hereditary and metabolic newborn screening;

2. Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and

3. Routine hearing screening consisting of one of the following:

a. Auditory brain stem response;

b. Otoacoustic emissions; or

c. Other appropriate, nationally recognized, objective physiological screening test.

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

F. Infertility Services

1. Definitions

ASRM means the American Society for Reproductive Medicine.

Infertility means a disease, condition, or status characterized by:

a. The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse in accordance with the guidelines of ASRM;

b. A person's inability to reproduce without medical intervention either as a single individual or with their partner; or

c. A licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Standard fertility preservation services means procedures that are consistent with established medical practices or professional guidelines published by ASRM or the American Society of Clinical Oncology for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

Treatment for infertility means procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons, including diagnosis, diagnostic tests, medication, surgery, or gamete intrafallopian transfer.

2. Eligibility. To be eligible, the member must meet the following criteria:

a. Be a covered under this Evidence of Coverage,

b. Have a diagnosis of Infertility, as defined above, and

c. The treatment must be deemed Medically Necessary and provided by a licensed physician specializing in reproductive endocrinology or infertility treatment.

3. Covered Services. The following Medically Necessary treatments for infertility are covered when authorized by CareFirst and provided consistent with a physician's or surgeon's overall plan of care.

a. Infertility counseling and diagnostic testing

b. Assisted reproductive technologies, including:

i. Artificial Insemination

ii. Intrauterine Insemination

iii. In Vitro Fertilization

a) Benefits include, per Member's lifetime with CareFirst, three (3) complete oocyte (egg) retrievals with unlimited embryo transfers from those egg retrievals or from any egg retrieval in

accordance with the guidelines of ASRM, using single embryo transfer when recommended and medically appropriate. When approved by CareFirst, additional egg retrievals beyond the third retrieval are covered only if the three prior retrievals were unsuccessful.

c. Standard fertility preservation services for Members with a medical condition or undergoing medical treatments that may result in infertility, including cryopreservation (freezing of eggs or sperm).

4. Coverage is not provided for:

a. Procedures deemed experimental or investigational by the FDA or ASRM.

b. Any charges associated with the collection and/or acquisition of donor eggs and/or donor sperm will not be covered.

c. Storage or thawing of embryos, eggs, or sperm, except that thawing of eggs (oocytes) which were preserved prior to January 1, 2025, is covered.

d. Infertility treatment does not include services to reverse surgically induced infertility, such as voluntary sterilization.

d. Assisted reproductive technologies that are not listed as a Covered Service.

f. Any Services or supplies provided, after an embryo transfer, to a person not covered under this Evidence of Coverage in connection with a surrogate/gestational carrier pregnancy.

g. The medical costs related to an embryo transfer to be made from an enrollee to a third-party; except, that the enrollee's coverage shall not extend to any medical costs of the surrogate or gestational carrier after the embryo transfer procedure.

1.6 Allergy Services

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

1.7 Rehabilitation Services

A. Definitions

Physical Therapy (PT) includes the short-term treatment that can be expected to result in a significant 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.

B. Covered Benefits
Coverage includes benefits for rehabilitation services including Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness or injury that CareFirst determines to be subject to improvement.

The goal of rehabilitation services is to return the individual to his/her prior skill and functional level.

1.8 Spinal Manipulation

A. Covered Services
Coverage is 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.

B. Limitations. Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.

1.9 Habilitative Services

A. For Members from birth to age 21.

Coverage for Habilitative Services include health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Benefits are not available for Habilitative Services delivered through early intervention and school services.

B. For Members age 21 and over.

1. Coverage for Habilitative Services include health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

2. Prior authorization is required.

1.10 Acupuncture Services. Benefits will be provided for Medically Necessary acupuncture services when provided by a provider licensed to perform such services.

1.11 Outpatient Therapeutic Treatment Services. Benefits are available for outpatient services rendered in a health care provider's office, 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 1, Outpatient Facility, Office and Professional Services.

Benefits include:

A. Hemodialysis and peritoneal dialysis;

B. Radiation therapy, including radiation administration;

C. Cardiac Rehabilitation benefits for Members who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation. Cardiac Rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Benefits include:

1. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription, and follow up examination for physician to adjust medication or change regimen; and

2. Increased outpatient rehabilitation services (physical therapy, speech therapy and occupational therapy) for Cardiac Rehabilitation of ninety (90) visits per therapy per Benefit Period.

3. Services must be provided at a place of service equipped and approved to provide Cardiac Rehabilitation.

D. Pulmonary rehabilitation benefits for Members who have been diagnosed with significant pulmonary disease.

1. Limited to one (1) program per lifetime.

2. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation services.

E. Transfusion services and Infusion Services, including home infusions, infusion of therapeutic agents, medication and nutrients, enteral nutrition into the gastrointestinal tract, chemotherapy and prescription medications;

F. Radioisotope treatment.

1.12 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.

1.13 Organ and Tissue Transplants

A. Coverage is provided for all Medically Necessary, non-Experimental/Investigational bone marrow, solid organ transplant, and other non-solid organ transplant procedures. Medical Necessity is determined by CareFirst.

B. Covered Services include the following:

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

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

3. Travel for organ transplants when a treatment option is not available within fifty (50) miles of the recipient Member's home. CareFirst will reimburse for reasonable and necessary cost of lodging and transportation for the recipient Member and a travel companion (or the recipient Member and two travel companions if the recipient Member is under the age of eighteen (18) years) to and from the Members home and site of the transplant.

Eligible travel reimbursement is determined by the United States Department of Treasury, Internal Revenue Service qualified medical expense reimbursement guidelines. Medical deductible applies for Health Savings Account (HSA) plans.

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

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

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

6. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant.

1.14 High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant

Benefits will be provided for high dose chemotherapy bone marrow or stem cell transplant treatment that is not Experimental/ Investigational, when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologists experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

1.15 Clinical Trial Patient Cost Coverage

A. Definitions

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

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

NIH means the National Institutes of Health.

Qualified Individual, as used in this section, means a Member who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to the prevention, early detection, treatment or monitoring of cancer, chronic disease, or other life-threatening illness, and the provider who recommended the Member for the clinical trial has concluded that the Member's participation in such trial is appropriate to prevent, detect early, treat or monitor cancer, chronic disease, or life-threatening illness, or the Member's participation is based on medical and scientific information.

Routine Patient Costs means the costs of all Medically Necessary items and health care services consistent with the Covered Services that are typically provided for a Qualified Individual who is not enrolled in a clinical trial that are incurred as a result of the item, device, or service being provided to the Qualified Individual for purposes of the clinical trial. Routine Patient Costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

B. Covered Services

1. Benefits for Routine Patient Costs to a Qualified Individual in a clinical trial will be provided if the Qualified Individual's participation in the clinical trial is the result of prevention, early detection, treatment or monitoring of cancer, chronic disease, or other life-threatening illness

2. Coverage for Routine Patient Costs will be provided only if:

   a) The item device or service 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 item device or service is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening disease or condition, or chronic disease;

   c) The item device or service is being provided in a federally funded or approved clinical trial approved by one of the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and quality, the Centers for Medicare and Medicaid Services, an NIH Cooperative Group, an NIH Center, the FDA in the form of an investigational new drug or device application, the federal Department of Defense, the federal Department of Veterans Affairs, the federal Department of Energy or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant,, 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 item device or service is being provided under a drug trial that is exempt from the requirement of an investigational new drug application.

   e) The facility and personnel providing the item device or service are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

3. Coverage is provided for the Routine Patient Costs 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 Qualified Individual'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.

1.16 Diabetes Equipment and Supplies, and Self-Management Training

A. If deemed necessary, diabetes outpatient self-management training and educational services, including Medical Nutrition Therapy, will be provided through an in-person program supervised by an appropriately licensed, registered, or certified CareFirst- approved facility or health care provider whose scope of practice includes diabetes education or management.

B. Diabetes educational services are covered without any Deductible, Copayment or Coinsurance when provided to a Member who is prediabetic or diabetic.

C. Coverage information for diabetic equipment and supplies is located in Section 10, Medical Devices and Supplies and Section 10, Prescription Drugs.

1.17 Dental Services

Pediatric dental benefits for Members up to age 19 are described in Section 2. Benefits will be provided to all Members for the following:

Accidental Injury

A. Covered Benefits
Dental benefits will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to a traumatic accidental injury if the injury did not arise while or as a result of biting or chewing. A traumatic accidental injury must be reported within six (6) months of the incident. Claims for traumatic accidental injury must include a comprehensive treatment plan with accompanying imaging, and progress notes must accompany any rehabilitative services with a narrative that may describe future procedures based on healing or outcomes of initial treatment. Traumatic accidental injury benefits are available up to thirty-six (36) months following the initial traumatic incident unless additional treatment is clearly indicated in the treatment plan.

As used in this provision, accidental injury means an injury to Sound Natural Teeth as a result of an external force or trauma resulting in damage to a tooth or teeth, surrounding bone and/or jaw.

B. Conditions and Limitations
Benefits are limited to Medically Necessary dental services as a restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury. Except as listed here, or in Section 1.19, 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 in Section 1.18.

C. Exclusions
Injuries to teeth that are not Sound Natural Teeth are not covered. Injuries as a result of biting or chewing are not covered.

1.18 Oral Surgery
Benefits include:

A. Medically Necessary procedures, as determined by CareFirst, to attain functional capacity, correct a congenital anomaly (excluding odontogenic congenital anomalies or anomalies limited to the teeth), reduce a dislocation, repair a fracture, excise tumors, non- odontogenic cysts or exostoses, or drain abscesses involving cellulitis and are performed on the lips, tongue, roof, and floor of the mouth, sinuses, salivary glands or ducts, and jaws.

B. Medically Necessary procedures, as determined by CareFirst, needed as a result of an accidental injury, when the Member requests oral surgical services or 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 will be provided up to three (3) years from the date of injury.

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

All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae (orthognathic surgery) for Cosmetic or other purposes or for correction of the malocclusion unrelated to a functional impairment that cannot be corrected non-surgically are excluded.

1.19 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.

1.20 Outpatient Surgical Procedures
A. Benefits are available for surgical procedures performed by a health care provider on an outpatient basis including, but not limited to, colonoscopy, sigmoidoscopy, and endoscopy.

B. Benefits are available for services in a hospital outpatient department or in an ambulatory surgical facility, in connection with a covered surgical procedure, including:

1. Use of operating room and recovery room.

2. Use of special procedure rooms.

3. Diagnostic procedures, laboratory tests, and radiology services.

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

5. Medical and surgical supplies.

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

1.21 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 provider 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.

1.22 Reconstructive Surgery
Benefits for reconstructive surgery are limited to surgical procedures that are Medically Necessary, as determined by CareFirst, and operative procedures performed on structures of the body to

improve or restore bodily function or to correct a deformity resulting from disease, trauma, or previous therapeutic intervention.

1.23 Reconstructive Breast Surgery
Benefits will be provided for reconstructive breast surgery resulting from a Mastectomy.

A. Reconstructive breast surgery means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery includes:

1. Augmentation mammoplasty;

2. Reduction mammoplasty; and

3. Mastopexy.

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

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

D. Coverage will be provided for treatment of physical complications at all stages of Mastectomy, including lymphedemas, in a manner determined in consultation with the Member and the Member's attending physician.

1.24 Retail Health Clinics
Coverage is provided for treatment of common conditions or ailments, which require rapid and specific treatment that can be administered in a limited duration of time. Retail Health Clinics are mini-medical office chains typically staffed by nurse practitioners with an on-call physician.

Retail Health Clinic services are non-emergency and non-urgent services for common ailments for which a reasonable person who possesses an average knowledge of health and medicine would seek in a Retail Health Clinic, including, but not limited to: ear, bladder, and sinus infections; pink eye; flu, and strep throat.

1.25 Urgent Care Services

Benefits are available for Urgent Care received from an Urgent Care center.

1.26 Emergency Services

Benefits are available for Emergency Services received in or through a hospital emergency room. Benefits include coverage for the costs of a voluntary HIV test, performed during a Member's visit to a hospital emergency room, regardless of the reason for the hospital emergency room visit.

1.27 Ambulance Services

Benefits are available for Medically Necessary air and ground ambulance services as determined by CareFirst.

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.

1.28 Telemedicine Services

A. Coverage shall be provided for the use of interactive audio, video, or other electronic media for the purpose of consultation, diagnosis, or treatment of the patient.

B. Benefits for telemedicine shall be provided by a health care provider to deliver health care services within the scope of the provider's practice at a site other than the site where the patient is located.

C. Benefits for telemedicine are not subject to any annual dollar maximum or annual visit limitation.

D. CareFirst shall not exclude a service from coverage solely because the service is provided through telemedicine and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine.

   Telemedicine does not include an electronic mail message, or facsimile transmission between a health care provider and a patient.

SECTION 2
PEDIATRIC DENTAL SERVICES

See the Prior Authorization Amendment for Covered Services that may require prior authorization.

2.1 Subject to the terms and conditions of this Description of Covered Services, benefits will be provided for the following Covered Dental Services when rendered and billed for by a Dentist as specified in the attached Schedules of Benefits.

2.2 Pediatric dental benefits for Members up to the end of the calendar year in which the Member turns age 19 will be provided in accordance with the High Option dental benefits of the Federal Employees Dental and Vision Insurance Program (FEDVIP) as specified in the Schedule of Benefits.

2.3 Class I - Preventive and Diagnostic Services

A. Services limited to twice per Benefit Period.

1. Oral examination including oral health risk assessment
2. Routine cleaning of teeth (dental prophylaxis)
3. Topical application of fluoride
4. Bitewing x-ray (not taken on the same date as those in B. below)
5. Pulp vitality tests; additional tests may be allowed for accidental injury and trauma, or other emergency

B. Services limited to one per 60 months

1. Intraoral complete series x-ray (full mouth x-ray including bitewings)
2. One panoramic x-ray and one additional set of bitewing x-rays

C. Services limited to once per tooth per 36 months: sealants on permanent molars

D. Space maintainers when Medically Necessary due to the premature loss of a posterior primary tooth

E. Services as required

1. Palliative Treatments once per date of service
2. Emergency Oral Exam once per date of service
3. Periapical and occlusal x-rays limited to the site of injury or infection
4. Professional consultation rendered by a Dentist, limited to one consultation per condition per Dentist other than the treating Dentist
5. Intraoral occlusal x-ray
6. One cephalometric x-ray

2.4 Class II - Basic Services

A. Direct placement fillings limited to:

1. Silver amalgam, resin-based composite, compomer, glass-ionomer or equivalent material accepted by the American Dental Association and/or the United States Food and Drug Administration

2. Direct pulp caps and indirect pulp caps

B. Non-Surgical periodontic services limited to:

1. Periodontal scaling and root planing once per 24 months per quadrant

2. Full mouth debridement to enable comprehensive periodontal procedure one per lifetime

3. Periodontal maintenance procedures four per 12 months

C. Simple extractions once per tooth per lifetime

2.5 Class III - Major Services - Surgical

A. Surgical periodontic services

1. Gingivectomy or gingivoplasty limited to one treatment per 36 months per Member per quadrant or per tooth

2. Osseous Surgery (including flap entry and closure) limited to one treatment per 36 months per Member per quadrant

3. Limited or complete occlusal adjustments in connection with periodontal treatment when services are received on a different date than restorative services

4. Mucogingival Surgery limited to grafts and plastic procedures; one treatment per site limited to one site or quadrant every 36 months

B. Endodontics

1. Apicoectomy

2. Pulpotomy for deciduous teeth once per tooth per lifetime per Member

3. Root canal for permanent teeth once per tooth per lifetime per Member

4. Root canal retreatment performed on permanent teeth limited to once per tooth per lifetime per Member

5. Root resection once per tooth per lifetime per Member

6. Pulpal therapy once per tooth per lifetime per Member

7. Endodontic therapy once per tooth per lifetime per Member

C. Oral Surgical services as required

1. Surgical extractions, including impactions once per tooth per lifetime per Member

2. Oral Surgery, including treatment for cysts, tumors and abscesses

3. Biopsies of oral tissue if a biopsy report is submitted

4. General anesthesia, intravenous (IV) sedation/analgesia, analgesia, and non-intravenous conscious sedation when Medically Necessary and administered by a

Dentist who has a license, permit, or certificate to administer conscious sedation or general anesthesia or board certified anesthesiologist (MD, DO, DDS, DMD).

5. Hemi-section

6. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

7. Vestibuloplasty

8. Services limited to once per lifetime per tooth:

a) Coronectomy

b) Tooth transplantation

c) Surgical repositioning of teeth

d) Alveoloplasty

e) Frenulectomy

f) Excision of pericoronal gingiva

2.6 Class IV - Major Services - Restorative

A. Crowns

1. Metal and/or porcelain/ceramic crowns and crown build-ups limited to one per 60 months per tooth

2. Metal and/or porcelain/ceramic inlays and onlays limited to one per 60 months per tooth

3. Stainless steel crowns

4. Recementation of crowns and/or inlays limited to once in any twelve (12) month period

5. Metal and/or porcelain/ceramic pontics limited to one per 60 months per tooth

B. Dental Implants are covered procedures only if determined to be Medically Necessary. If CareFirst determines an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures, and only the second phase of treatment (the prosthodontic phase of placing of the implant crown or partial denture) will be a Covered Dental Service.

1. Endosteal implant limited to one per 60 months

2. Surgical placement of interim implant body limited to one per 60 months

3. Eposteal implant limited to one per 60 months

4. Transosteal implant limited to one per 60 months

5. Implant supported complete denture

6. Implant supported partial denture

C. Dentures

1. Partial removable dentures, upper or lower, limited to one per 60 months

2. Complete removable dentures, upper or lower, limited to one per 60 months

3. Pre-operative radiographs required

4. Pre-treatment estimate, as described in the Estimate of Eligible Benefits section is recommended for Members

5. Tissue conditioning prior to denture impression

6. Repairs to denture as required including: repair resin denture base, repair cast framework, addition of tooth or clasp to existing partial denture, replacement of broken tooth, repairs or replacement of clasp, recement fixed partial denture

D. Denture adjustments and relining limited to: Full or partial removable (upper or lower) dentures: once per 24 months, but not within six months of initial placement

E. Repair of prosthetic appliances, including fixed bridges, and removable dentures, full and/or partial.

F. Occlusal guard, by report, limited to one per 12 months for Members age 13 and older

G. Fixed prosthetics, including bridges and crowns, inlays and onlays used as abutments for or as a unit of the bridge limited to one per tooth per 60 months

2.7 Class V - Orthodontic Services

A. Benefits for orthodontic services will only be available until the end of the calendar year in which the Member turns age 19 if the Member:

1. Has fully erupted permanent teeth with at least 1/2 to 3/4 of the clinical crown being exposed (unless the tooth is impacted or congenitally missing); and

2. Has a severe, dysfunctional, handicapping malocclusion and is determined to be Medically Necessary.

B. All comprehensive orthodontic services require a pre-treatment estimate (PTE) by CareFirst, as described in the Estimate of Eligible Benefits section. The following documentation must be submitted with the request for a PTE:

1. ADA 2006 or newer claim form with service code requested;

2. A complete series of intra-oral photographs;

3. Diagnostic study models (trimmed) with waxbites or OrthoCad electronic equivalent, and

4. Treatment plan including anticipated duration of active treatment.

C. Covered benefits if a PTE is approved

1. Retainers

a) One set (included in comprehensive orthodontics)

b) Replacement allowed one per arch per lifetime within 12 months of date of debanding, if necessary

c) Rebonding or recementing fixed retainer

2. Pre-orthodontic treatment visit

3. Braces once per lifetime

4. Periodic treatment visits; not to exceed 24 months (the Member must be eligible for Covered Dental Services on each date of service).

D. Payment policy: one initial payment for comprehensive orthodontic treatment, a pre-orthodontic treatment visit and periodic orthodontic treatment visits (not to exceed 24 periodic orthodontic treatment visits).

1. When a Preferred Dentist or Participating Dentist provides the comprehensive orthodontic treatment, additional periodic orthodontic treatment visits beyond 24 will be the orthodontist's financial responsibility and not the Subscriber's. Subscribers may not be billed for broken, repaired, or replacement of brackets or wires. Visits to repair or replace brackets or wires are not separately reimbursable from periodic visits.

2. When a Non-Participating Dentist provides the comprehensive orthodontic treatment, additional periodic orthodontic treatment visits beyond 24 will not be Covered Dental Services. The Member is responsible for the difference between the CareFirst payment for Covered Dental Services and the Non-Participating Dentist's charge.

E. In cases where the Member has been approved for comprehensive orthodontic benefits, and the parent has decided they do not wish to have the child begin treatment at this time or any time in the near future, the provider may bill for their records, to include the treatment plan, radiographs, models, photos, etc. and explaining the situation on the claim for payment. The reimbursement for these records is the same as if the orthodontic services had been rendered.

F. If the case is denied, the provider will be informed that CareFirst will not cover the orthodontic treatment. However, Covered Dental Services will include the pre- orthodontic visit which included treatment plan, radiographs, and/or photos, records and diagnostic models for full treatment cases only.

SECTION 3
PEDIATRIC VISION SERVICES

See the Prior Authorization Amendment for Covered Services that may require prior authorization

3.1 Covered Services

Coverage will be provided for pediatric vision benefits for children up to age 19 in accordance with the Federal Employee Program Blue Vision high plan. Benefits include:

A. One routine eye examination, including dilation, if professionally indicated, each Benefit Period. A vision examination may include, but is not limited to:

1. Case history;
2. External examination of the eye and adnexa;
3. Ophthalmoscopic examination;
4. Determination of refractive status;
5. Binocular balance testing;
6. Tonometry test for glaucoma;
7. Gross visual field testing;
8. Color vision testing;
9. Summary finding; and
10. Recommendation, including prescription of corrective lenses.

B. Frames and Spectacle Lenses or Contact Lenses

1. Prescribed frames and spectacle lenses or contact lenses, including directly related provider services such as:

a) Measurement of face and interpupillary distance;

b) Quality assurance; and

c) Reasonable aftercare to fit, adjust and maintain comfort and effectiveness.

2. One pair of frames per Benefit Period; and

3. One pair of prescription spectacle lenses per Benefit Period

a) Spectacle lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, ultraviolet protective coating, standard progressives, and plastic photosensitive lenses (Transitions®).

b) Polycarbonate lenses are covered in full for monocular patients and patients with prescriptions > +/- 6.00 diopters.

c) All spectacle lenses include scratch resistant coating with no additional Copayment. There may be an additional charge at Walmart and Sam's Club

4. Contact Lenses

a) Contact lens evaluation, fitting, and follow-up care.

b) Elective contact lenses (in place of frames and spectacle lenses):

(1) One pair of elective prescription contact lenses per Benefit Period; or,

(2) Multiple pairs of disposable prescription contact lenses per Benefit Period.

c) One pair of Medically Necessary prescription contact lenses per Benefit Period in lieu of other eyewear.

(1) Prior authorization must be obtained from the Vision Care Designee by calling the Vision Care Designee at the telephone number on the Member's identification card.

(2) Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. Contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and/or irregular astigmatism.

C. Low vision services, including one comprehensive Low Vision evaluation every 5 years, 4 follow-up visits in any 5-year period and prescribed low vision aid optical devices, such as high-powered spectacles, magnifiers and telescopes. Ophthalmologists and optometrists specializing in low vision care will evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for Members with low vision.

D. Covered Vision Services and benefits for services provided by Non-Contracting Vision Providers are limited. See the Schedule of Benefits.

3.2 Warranty

The Vision Care Designee's collection frames and all eyeglass lenses manufactured in the Vision Care Designee laboratories are guaranteed for one year from the original date of dispensing.

Warranty limitations may apply to provider-supplied or retailer-supplied frames and/or eyeglass lenses. The Contracting Vision Provider can provide the details of the warranty that is available to the Member.

3.3 Limitations

Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year. Benefits for the treatment of medical conditions of the eye are covered under Section 1.

SECTION 4
INPATIENT HOSPITAL SERVICES

See the Prior Authorization Amendment for Covered Services that may require prior authorization

4.1 Covered Inpatient Hospital Services

A Member will receive benefits for the 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, Medical, and Surgical Services

Medically Necessary inpatient physician, medical, and surgical services provided by or under the direction of the attending physician and ordinarily furnished to a patient while hospitalized.

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, anesthesia, 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 and transfusions 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 dental implants, fixed or removable dental Prosthetics, artificial limbs, or other external Prosthetics, which may be provided under other provisions of this Description of Covered Services.

6. Medical social services.

4.2 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 admission will not exceed any applicable benefit

limitation. The limit, if any, on hospitalization for rehabilitation 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.

In consultation with the Member's attending physician, the Member may elect to stay less than the minimum prescribed above when appropriate.

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 Member's attending physician, the Member may elect to stay less than the minimum prescribed above when appropriate.

D. Childbirth

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

1. Forty-eight (48) hours for both the mother and newborn following a routine vaginal delivery;

2. Ninety-six (96) hours for both the mother and newborn following a routine cesarean section.

Prior authorization is not required for maternity admissions.

Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, coverage includes additional hospitalization for the newborn for up to four (4) days.

If the delivery occurs in the hospital, the length of stay begins at the time of the delivery. If the delivery occurs outside of the hospital, the length of stay begins upon admission to the hospital. The Member and the attending physician may agree to an early discharge.

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 2.5 of the Evidence of Coverage describes the steps, if any, necessary to enroll a newborn Dependent child.

4.3 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 5
SKILLED NURSING FACILITY SERVICES

See the Prior Authorization Amendment for Covered Services that may require prior authorization.

5.1 Covered Skilled Nursing Facility Services

When the Member meets the conditions for coverage listed in Section 5.2, the services listed below are available to Members in a Skilled Nursing Facility:

A. Room and board in a semiprivate room;

B. Inpatient physician and medical services provided by or under the direction of the attending physician; and

C. Services and supplies that are not Experimental/Investigational, as determined by CareFirst, and ordinarily furnished by the facility to inpatients for diagnosis or treatment.

5.2 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 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. 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.

C. 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.

5.3 Custodial Care is Not Provided

Benefits will not be provided for any day in a Skilled Nursing Facility that CareFirst determines is primarily for Custodial Care. Services may be deemed Custodial Care even if:

A. A Member cannot self-administer the care;

B. No one in the Member's household can perform the services;

C. Ordered by a physician;

D. Necessary to maintain the Member's present condition; or

E. Covered by Medicare.

SECTION 6
HOME HEALTH CARE SERVICES

See the Prior Authorization Amendment for Covered Services that may require prior authorization.

6.1 Covered Home Health Care Services Benefits are provided for:

A. Continued care and treatment provided by or under the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Services of a home health aide, medical social worker, or registered dietician may be provided, but must be performed under the supervision of a licensed professional (RN or LPN) nurse.

B. Drugs and medications
Drugs and medications directly administered to the patient during a covered home health care visit and incidental Medical Supplies directly expended in the course of a covered home health care visit are covered.

C. Home Health Care Services authorized or approved by CareFirst as Medically Necessary under the utilization management requirements as meeting the conditions for coverage.

Purchase or rental of Durable Medical Equipment is not covered under this provision. See Section 9.2.A, Durable Medical Equipment, for benefit information.

6.2 Conditions for Coverage Benefits are provided when:

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 are 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 requires and continues 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 is not Custodial in nature.

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

F. All services must be arranged and billed by the Qualified Home Health Agency. Providers may not be retained directly by the Member.

6.3 Additional Home Health Care Benefits

A. Home Visits Following 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 provided under this provision do not count toward any Home Health Care visit maximum.

B. Home Visits Following a Mastectomy

1. For a Member who has a shorter hospital stay than that provided under Section 4.2.B, 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 4.2.B, Inpatient Coverage Following a Mastectomy, coverage will be provided for a home visit if prescribed by the Member's attending physician

3. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

C. 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 4.2.D, Childbirth, benefits will be provided for:

   a) One home visit scheduled to occur within 24 hours after hospital discharge; and

   b) An additional home visit if prescribed by the attending physician.

2. For a mother and newborn child who remain in the hospital for at least the length of time provided under Section 4.2.D, Childbirth, benefits will be provided for a home visit if prescribed by the attending physician.

3. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

D. Home Based Care
Members with Chronic Conditions. For a member who has been identified with a chronic condition with certain risk factors as designated by a CareFirst clinical professional, benefit will be provided for an additional home visit if prescribed by the Member's attending physician.

SECTION 7
HOSPICE CARE SERVICES

See the Prior Authorization Amendment for Covered Services that may require prior authorization.

7.1 Covered Hospice Care Services

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.

A. Inpatient and outpatient care;

B. Intermittent Skilled Nursing Care;

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

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

E. Non-Custodial home health visits.

F. 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;

G. Laboratory test and x-ray services;

H. Medically Necessary ground ambulance, as determined by CareFirst;

I. 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; and

J. 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.

7.2 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.

7.3 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.

SECTION 8
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

See the Prior Authorization Amendment for Covered Services that may require prior authorization.

8.1 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, D.C.)

Mental Health and Substance Use Disorder Management Program refers to utilization management, benefits administration, and provider network activities administered by or on behalf of CareFirst to ensure that mental health and Substance Use Disorder services are Medically Necessary and provided in a cost-effective manner.

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

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 Use Disorder or Alcohol Use Disorder 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-hospital residential facility certified by the District of Columbia or by any jurisdiction in which it is located, as a qualified non-hospital provider of treatment for Drug Use Disorder, Alcohol Use Disorder, Mental Illness, or any combination of these, in a residential setting. A non-hospital residential facility includes any facility operated by the District of Columbia, any state or territory or the federal government to provide these services in a residential setting. It is not a facility licensed as a general or special hospital. A non-hospital residential facility also must meet or exceed guidelines established for such a facility by CareFirst.

Substance Use Disorder means:

A. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or

B. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Substance Use Disorder Program means the CareFirst program for Members with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

8.2 Outpatient Mental Health and Substance Use Disorder Services

Covered Services include the following:

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

B. Diagnosis and treatment for Substance Use Disorder, including detoxification and rehabilitation services as an outpatient in a covered alcohol or drug rehabilitation program or Qualified Partial Hospitalization Program designated by CareFirst.

C. Other covered medical services and medical ancillary services for conditions related to Mental Illness, Emotional Disorders, and Substance Use Disorder.

D. Office visits for medication management in connection with Mental Illness, Emotional Disorders, and Substance Use Disorder.

E. Methadone maintenance treatment.

F. Partial Hospitalization in a Qualified Partial Hospitalization Program.

G. Electroconvulsive therapy.

H. Selected Providers

1. Definitions

Virtual Care means the use of digital technology interaction for the purpose of consultation, diagnosis, management, and/or treatment of the patient.

Virtual Connect Providers means a provider who contracts with CareFirst and is selected to provide preventive services, PCP office visit services, mental health/Substance Use Disorder services, and Virtual Care office visit services to Members.

Selected Provider means a provider who contracts with CareFirst and is selected to provide preventive services, PCP office visit services, and mental health/Substance Use Disorder office visit services in person or via Virtual Care to Members.

2. Covered Services

a) Benefits are provided for Medically Necessary care by a Selected Provider.

b) For Covered Services with visit limitations, these visit limitations will apply to the Selected Provider(s).

c) To learn more about the Selected Providers and how to access care, please visit www.carefirst.com/virtualconnect program.

8.3 Inpatient Mental Health and Substance Use Disorder Services

Benefits are provided when the Member is admitted as an inpatient in a hospital or other CareFirst-approved health care facility for treatment of Mental Illness, Emotional Disorders, and Substance Use Disorder as follows:

A. Hospital benefits will be provided, as described in Section 4, Inpatient Hospital Services, of this Description of Covered Services, on the same basis as a medical (non-Mental Health or Substance Use Disorder) admission.

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

The following 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 provider visits during the Member's hospital stay;

2. Intensive care that requires a health care provider's attendance;

3. Consultation by another health care provider when additional skilled care is required because of the complexity of the Member's condition; and

C. Benefits are available for diagnosis and treatment for Substance Use Disorder, including inpatient detoxification and rehabilitation 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. Electroconvulsive therapy.

8.4 Substance Use Disorder Program

A. Program benefits will be provided for outpatient treatment of Substance Use Disorder in accordance with the Substance Use Disorder Program if:

1. The Member qualifies for the Substance Use Disorder Program, as determined by CareFirst.

2. The Member receives treatment from a Designated Provider, as determined by CareFirst;

3. Treatment is rendered though an intensive outpatient program (IOP) at a Designated Provider as determined by CareFirst.

B. There is no Deductible, Copayment and/or Coinsurance associated with services provided under this program. Except for Health Savings Account (HSA)-compatible plans, the Deductible, if any, does not apply to Covered Service provided under this provision.

SECTION 9
MEDICAL DEVICES AND SUPPLIES

See the Prior Authorization Amendment for Covered Services that may require prior authorization.

9.1 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 health care provider;

D. Is consistent with the diagnosis;

E. Is appropriate for use in the home;

F. Is reusable; and

G. Can withstand repeated use.

Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry, including a disease for which the 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 Devices means Durable Medical Equipment, medical formulas, Medical Supplies, Orthotic Devices and Prosthetic Devices.

Medical Food means a food that is:

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

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

Medical Supplies means items that:

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

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

C. Are ordered or prescribed by a health care provider;

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 Devices means orthoses and braces which:

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

B. Are prescribed by a health care provider;

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

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

E. Include devices necessary for post-operative healing.

Prosthetic Devices means devices which:

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

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

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

D. Are prescribed by a health care provider; and

E. Are removable and attached externally to the body.

9.2 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, shipping, and taxes.

B. Medical Supplies

C. Medical Foods and Low Protein Modified Food Products. Medical Foods and Low Protein Modified Food Products are covered if the Medical Foods or Low Protein Modified Food Products are:

1. Prescribed as Medically Necessary for therapeutic treatment of:

a. Inflammatory bowel disease, including Crohn's disease, ulcerative colitis, and indeterminate colitis;

b. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;

c. Immunoglobulin E- and non-Immunoglobulin E-mediated allergies to food proteins;

d. Food protein-induced enterocolitis syndrome;

e. Eosinophilic disorders, including eosinophilic esophagitis, eosinophilic gastroenteritis, eosinophilic colitis, and post-transplant eosinophilic disorders;

f. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract, including short bowel syndrome and chronic intestinal pseudo-obstruction;

g. Malabsorption due to liver or pancreatic disease; or

h. Inherited metabolic disorders; and

2. Administered under the direction of a physician.

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

E. 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. Coverage includes Medically Necessary and medically appropriate equipment and diabetic supplies necessary for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.

3. Benefits for insulin syringes and other diabetic supplies described herein are covered in Section 10, Prescription Drugs. All other diabetic equipment is covered as a medical device or supply.

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

G. Orthotic Devices and Prosthetic Devices Benefits include:

1. Supplies and accessories necessary for effective functioning of a 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.

9.3 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.

9.4 Benefit Limits

Benefits are limited to the least expensive Medically Necessary Durable Medical Equipment, Medical Supply, Orthotic Device or Prosthetic adequate to meet the patient's medical needs.

Purchase or rental of any Medical Device is at the discretion of CareFirst. 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, and 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 any Member Copayment or Coinsurance) and the Member will be fully responsible for paying the remaining balance.

9.5 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 Description of Covered Services.

SECTION 10
PRESCRIPTION DRUGS

See the Prior Authorization Amendment for Covered Services that may require prior authorization.

10.1 Covered Services

Benefits will be provided for Prescription Drugs, including but not limited to:

A. Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. See Section 1.5.B, Contraceptive Methods and Counseling, for additional coverage of contraceptive drugs and devices.

B. Human growth hormones. Prior authorization is required.

C. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preventive Drug List.

Nicotine Replacement Therapy. Nicotine Replacement Therapy means a product, including a product on the Preventive Drug List 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. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.

D. Injectable medications that are self-administered and the prescribed syringes and needles.

E. Standard covered items such as insulin, glucagon and anaphylaxis kits.

F. Fluoride products.

G. Diabetic Supplies.

H. Oral chemotherapy drugs.

I. Hormone replacement therapy drugs.

J. Abortion Care. Coverage will be provided for abortion care Prescription Drugs. There is no Deductible, Copayment or Coinsurance for abortion care Prescription Drugs. Except for Health Savings Account (HSA)-compatible plans to which the Member has contributed to his/her HSA during the Benefit Period, the Deductible, if any, does not apply to abortion care Prescription Drugs.

10.2 Dispensing.

A. Non-Maintenance Drugs are limited to up to a thirty (30)-day supply.

B. Maintenance Drugs

1. Coverage for a Maintenance Drug is limited to a thirty (30) day supply for:

a) The first prescription; or,

b) A change in prescription.

2. The day supply for Maintenance Drugs will be based on the following:

a) the prescribed dosage;

b) standard manufacturer's package size, and

c) specified dispensing limits.

C. A Member may obtain up to a twelve (12) month supply of contraceptives at tone time.

10.3 Mail Order Program. Except as provided in Section 11.4, all Members have the option of ordering Covered Prescription Drugs via a contracted mail order pharmacy. A Member may obtain up to a twelve (12) month supply of contraceptives at one time.

10.4 Benefits for Specialty Pharmacy Prescription Drugs. Benefits will be provided for Covered Specialty Drugs only when obtained from a Pharmacy that is part of the Exclusive Specialty Pharmacy Network.

SECTION 11
TOTAL CARE

See the Prior Authorization Amendment for Covered Services that may require prior authorization

11.1 Definitions.

Care Management Team means the health care providers involved in the collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan, as used in this provision, means the plan directed by a health care provider, and coordinated by a medical or behavioral health care coordinator and Care Management Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the Total Care goals and objectives.

Total Care Program means medical and associated services directed by the Total Care team of healthcare professionals to:

A. Foster the health care provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;

B. Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and,

C. Exchange medical information with CareFirst, other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.

Qualifying Individual, as used in this provision, means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the Total Care Program.

11.2 Covered Benefits. Benefits will be provided for the costs associated with the coordination of care for the Qualifying Individual's medical conditions, including:

A. Assess the Qualifying Individual's medical needs;

B. Provide liaison services between the Qualifying Individual and the health care provider(s) and the Care Management Team;

C. Create and supervise the Care Plan;

D. Educate the Qualifying Individual and family regarding the Qualifying Individual's disease and self-care techniques;

E. Arrange for consultations with Specialists and other Medically Necessary supplies and services, including community resources, for the Member; and,

F. Assess treatment compliance.

11.3 Limitations. Benefits provided through the Total Care Program are available only when provided by a CareFirst-approved health care provider who has elected to participate in the Total Care Program.

SECTION 12
CARE SUPPORT PROGRAMS

12.1 Definitions

Care Support Programs are health care and wellness programs designed to promote the collaborative process of assessment, planning, and facilitation, and advocacy for options and services to meet a Qualified Individual's health needs through communication and available resources to promote quality cost-effective outcomes. Care Support Programs include but are not limited to; care coordination, case management, condition specific support, enhanced monitoring, informed decision-making support, disease management, lifestyle coaching, health promotion and wellness programs.

Designated Provider means a provider or vendor contracted with CareFirst to provide services under CareFirst's Care Support Programs, and who has agreed to participate in Care Support Programs in cooperation with CareFirst for Members with complex chronic disease, high risk acute conditions or lifestyle behavior change.

Qualified Individual, as used in this provision, means a Member with certain conditions, complex health care needs or other risk factors, as determined by CareFirst, requiring care support and coordination of health services. The Member agrees to participate and comply with any and all elements in any given Care Support Program.

12.2 Covered Services

A. Care Support Programs are available to Qualified Individuals to manage the care of certain complex chronic or high-risk acute diseases when provided by Designated Providers or through CareFirst and are covered at no cost to the Qualified Individual.

B. If the Qualified Individual's Evidence of Coverage is compatible with a federally- qualified Health Savings Account and the Qualified Individual has funded his/her HSA account during the Benefit Period, then the Qualified Individual may be responsible for any fees associated with the Member's participation in a Care Support Program until the annual Deductible has been met.

C. Exclusions and Limitations. Coverage will not be provided for the services listed in this amendment when rendered by non-Designated Providers.

SECTION 13
GENERAL PROVISIONS

13.1 How the Plan Works

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

A. In-Network Benefits

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

1. Services Rendered by a Preferred Provider

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

2. 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 Covered Services are provided by a provider who is not a Preferred Provider or in a circumstance not addressed in Section A. When Out-of- Network benefits apply, covered services may be eligible for reduced benefits. When a Member uses a provider that is not a Preferred Provider, benefits are based on the appropriate Allowed Benefit. The level of Out-of-Network Benefits is shown in the Schedule of Benefits. The Member may be responsible for amounts in excess of the Allowed Benefit for services by a provider who is not a Preferred Provider**.**

13.2 Continuing Care with Terminated Providers

A. When a Preferred Provider terminates their agreement with CareFirst, for any reason except for cause, benefits will be provided for continuing care rendered by the terminated provider as described in this section. CareFirst will send a notice to the Member that the Preferred Provider is no longer available.

B. The Member may, upon request, continue to receive Covered Services from his/her provider for up to 90 days after the date of the notice of the provider termination from CareFirst provider panel, if termination was for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status. In addition, a Member may continue treatment with a terminated provider if:

1. A Member was in an active course of treatment with the terminated provider prior to the date the Member was notified. The Member needs to request, from CareFirst, to continue receiving care from the terminated provider. Benefits will be provided for a period of 90 days from the date the Member is notified by CareFirst that the terminated Provider is no longer available.

2. A Member who has entered her second trimester of pregnancy may continue to receive Covered Services from the terminated provider through postpartum care directly related to the delivery.

3. A Member that was terminally ill (as defined by § 1861(dd)(3)(A) of the Social Security Act) at the time the provider's agreement terminated may continue to receive Covered Services directly related to the treatment of the terminal illness until the Member dies.

13.3 Limitation on Provider Coverage

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

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

13.4 Pediatric Vision Coverage.

A. When the Member receives a vision examination from a Contracting Vision Provider, the benefit payment is accepted as payment in full.

B. When a Member receives frames and spectacle lenses or contact lenses from a Contracting Vision Provider, the Member's responsibility is as stated below. The benefit payment is as stated in the attached Schedule of Benefits.

1. When the Member receives frames from the display of collection frames (the collection designated by the Vision Care Designee) and basic spectacle lenses from a Contracting Vision Provider, the benefit payment is accepted as payment in full.

2. When the Member receives other frames, non-basic spectacle lenses or contact lenses from a Contracting Vision Provider, the Member is responsible for the cost difference between the Vision Care Designee's payment and the Contracting Vision Provider's actual charge.

C. When the Member receives Covered Vision Services from a Non-Contracting Vision Provider, the Member is responsible for the cost difference between the Vision Care Designee's payment and the Non-Contracting Vision Provider's actual charge. The Vision Care Designee's payment is stated in the Schedule of Benefits.

Limited Access Area: If the Member resides in an area that does not have adequate access to a Contracting Vision Provider and the Member receives Vision Care from a Non-Contracting Vision Provider, the Vision Care Designee will pay up to 100% of the Allowed Benefit. The Member is responsible for any difference between the amount billed and the Vision Care Designee's payment. To determine if the Member resides in a limited access area, the Member must call the Vision Care Designee at the telephone number on the Member's identification card.

13.5 Pediatric Dental Coverage

A. The Member has the exclusive right to choose a Dentist. Whether a Dentist is a Preferred or Participating Dentist or not relates only to method of payment, and does not imply that any Dentist is more or less qualified than another.

B. CareFirst makes payment for Covered Dental Services, but does not provide these services. CareFirst is not liable for any act or omission of any Dentist.

C. Services of Participating Dentists

1. Claims will be submitted directly to CareFirst by the Dentist.

2. CareFirst will pay benefits directly to the Dentist.

3. The Member is responsible for only the Deductible and Coinsurance.

D. Services of Non-Participating Dentists

1. Claims may be submitted directly to CareFirst by the Non-Participating Dentist or the Member. In either case, it is the responsibility of the Member to make sure that proof of loss is filed on time as stated in the Proof of Loss section of the Evidence of Coverage.

2. All benefits for Covered Dental Services rendered by a Non-Participating Dentist will be payable to the Subscriber or to the Non-Participating Dentist, at the discretion of CareFirst.

3. The Member is responsible for the difference between the CareFirst payment and the Non-Participating Dentist’s charge.

E. Services of Preferred Dentists

1. Many Participating Dentists have special agreements with CareFirst and are part of a network of Preferred Dentists. In general, if a Member chooses a Preferred Dentist, the cost to the Member is lower than if the Member chooses a Non- Preferred Dentist. In the Schedule of Benefits, the Coinsurance percentages are listed as either “In-Network” (for a Preferred Dentist) or “Out-of-Network” (for a Non-Preferred Dentist).

2. If a Preferred Dentist is not reasonably available when a Member requires emergency care (Palliative Treatment and/or Emergency Oral Exam), benefits will be paid based on the "In-Network" Coinsurance percentage listed in the Schedules of Benefits. Participating Dentists will accept the Allowed Benefit as payment in full, except for any applicable Deductible and Coinsurance amounts for which the Member is responsible. Non-Participating Dentists may bill the Member for the difference between the CareFirst payment and the Non- Participating Dentist's charge.

F. Estimate of Eligible Benefits

A Dentist may propose a planned dental treatment or series of dental procedures. A Member may choose to obtain a written estimate of the benefits available for such procedures.

CareFirst encourages a Member to obtain a written Estimate of Eligible Benefits (CareFirst’s written estimate of benefits before a service is rendered) also known as a pre- treatment estimate (PTE) for major dental procedures, thereby alerting a Member of the out-of-pocket expenses that may be associated with the treatment plan, related deductibles, co-insurance

and/or procedures that are not Covered Dental Services. Based on an Estimate of Eligible Benefits or PTE from CareFirst, a Member can decide whether or not to incur the expense that may be associated with a particular treatment plan.

Failure to obtain an Estimate of Eligible Benefits or PTE has no effect on the benefits to which a Member is entitled. A Member may choose to forgo the Estimate of Eligible Benefits or PTE and proceed with treatment.

After the services are rendered, the claim will be reviewed by CareFirst. Should the review determine that the service(s) rendered meet CareFirst's criteria for benefits, the benefits will be provided as described in this Description of Covered Services. However, should the review of the claim determine that the treatment or procedures did not meet CareFirst's criteria for benefits, benefits will not be provided.

To request an Estimate of Eligible Benefits or PTE prior to receiving dental treatment or dental procedures, a Member should contact his or her Dentist who will coordinate the request on the Member's behalf. If the Dentist has any questions about the process, he or she may contact the CareFirst Provider Services Department or go to the CareFirst website at www.carefirst.com, which lists information in the Physicians and Providers section, under the subsection for Dental, and list of Resources. The Estimate of Eligible Benefits or PTE is merely an estimate, and it cannot be considered a guarantee of the Member's benefits or enrollment.

The process is different for orthodontic services. The Affordable Care Act requires that orthodontics must be Medically Necessary to be Covered Dental Services. To request a PTE for orthodontic services, the Member must see an orthodontist who will do an exam and orthodontic assessment that may include taking orthodontic records (study models and certain x-rays). The orthodontist will then complete a case assessment using a scoring tool required by the state. Then the orthodontic records and case assessment will be sent to CareFirst for evaluation and confirmation of the assessment score. If the score meets or exceeds the baseline requirement, the orthodontics will be approved for the Member. If the score is less than the minimal required score, then the request for orthodontic benefits will be denied.

A decision by CareFirst to deny benefits as described in this section constitutes an Adverse Decision if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

13.6 Prescription Drug Coverage.

A. Accessing the Prescription Drug Benefit Card Program.

1. Members may use his/her identification card to purchase Covered Prescription Drugs from Contracting Pharmacy Providers. If the Prescription Drug coverage includes a Deductible, the Member must pay the entire cost of the Covered Prescription Drug(s) until the Deductible is satisfied. Once the Deductible, if applicable, has been satisfied, the Member pays the appropriate Copayment or Coinsurance as stated in the Schedule of Benefits.

2. For Covered Prescription Drugs or diabetic supplies purchased from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. In cases of Emergency Services or Urgent Care received outside of the Service Area, Members will be entitled to reimbursement from CareFirst or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance. In all other cases, Members will be entitled to reimbursement from CareFirst or its designee for the

amount up to the Prescription Drug Allowed Benefit, minus any applicable Deductible, or Copayment or Coinsurance.

3. Except for Specialty Drugs, Members have the option of ordering Covered Prescription Drugs via mail order. The mail order program provides Members with a Pharmacy that has an agreement with CareFirst or its designee, to provide mail service for Covered Prescription Drugs in accordance with the terms of this provision. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance.

B. Additional Terms and Conditions

1. Providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Covered Prescription Drug in the Prescription Guidelines. A copy of the Prescription Guidelines is available to the Member or provider upon request. This requirement applies when a Member chooses to obtain a Covered Prescription Drug from a Contracting Pharmacy Provider or from a Non-Contracting Pharmacy Provider.

2. Providers may substitute a Generic Drug for a Brand Name Drug. If there is no Generic Drug for the Brand Name Drug the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits for Preferred Brand Name Drugs or Non-Preferred Brand Name Drugs.

3. If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug.

4. When a Generic version of a Prescription Drug becomes available, the Brand Name Drug may be removed from the Formulary or moved to the Non-Preferred level.

5. Members must use 80% of a dispensed non-Maintenance Drug or Maintenance Drug in the manner prescribed before a refill of that prescription can be obtained.

C. Exception Requests for Drug Coverage Determination.

1. The Member's provider may request an exception for drug coverage determination. These exceptions include:

a. Non-Formulary Drug Exceptions – a request to cover a Non-Formulary Drug

b. Tier Exceptions – a request to cover a Non-Preferred Brand Name Drug at a lower tier cost share

c. Brand Exceptions – a request to cover a Non-Preferred Brand Name Drug at the applicable cost-share when a Generic alternative is available

d. Maintenance Medical Exceptions – a request for a Prescription Drug to be considered a Maintenance Drug

e. Step Therapy Exceptions – a request for a Prescription Drug to bypass Step Therapy guidelines

2. The Member's provider may request an exception based upon Medical Necessity by submitting an exception form to CareFirst. A separate exception form is required for each of the exception scenarios in Section 13.6C.1. Determination will be based on Medical Necessity, the tier of the requested Prescription Drug, and the Member's benefits.

3. Upon review by CareFirst, the prescribing provider and the Member will be notified of the decision.

   a. If the exception request is denied, the denial shall be considered an Adverse Decision and may be appealed in accordance with the process outlined in the Benefit Determination and Appeals Amendment.

   b. In addition, if the exception request is denied, the Member, the Member's representative or the prescribing provider may submit an external exception request to CareFirst requiring that the original exception request and subsequent denial be reviewed by an independent review organization.

4. Timeframe for review and notification of outcome of exception request:

   a. Urgent requests based on exigent circumstances from the Member's prescribing provider will be completed within twenty-four (24) hours of receipt of the information necessary to make the determination.

      For purposes of this provision, exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment.

   b. Non-urgent requests will be completed within two (2) business days of receipt of the information necessary to make the determination.

   c. A request for an external review of the original exception request will be completed no later than twenty-four (24) hours after receipt of the request if the original exception request was urgent and two (2) business days following receipt of the request if the original exception request was non-urgent.

13.7 For the following benefits, the Member payment of any Deductible, Copayment, or Coinsurance for covered services provided by Non-Contracting Providers shall be the same Member payment required for Contracting Provider services, and the Member is not responsible for amounts above any Deductible, Copayment, or Coinsurance. CareFirst will make payments for the surprise bill protected items and services directly to the non-contracting provider. Any cost- sharing payments made with respect to surprise bill protected items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum.

A. Emergency Services. For Emergency Services, the Allowed Benefit for a Covered Service is the Recognized Amount. The benefit is payable to the Non-Contracting provider. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits.

B. Non-Emergency Services provided to a Member at a Contracting Provider facility that are provided by a Non-Contracting Provider where the Member has not been given appropriate notice and consented to receive services from a Non-Contracting Provider. For Non- Emergency Services performed by Non-Contracting at In-Network facilities (including Ancillary Services and services for unforeseen urgent medical needs),the Allowed Benefit for a Covered Service is the Recognized Amount. The benefit is payable to the Non- Contracting provider. Additionally,

the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits.

C. Air ambulance services. For Non-Contracting Providers of Air Ambulance Services, the Allowed Benefit is the lesser of the provider's actual charge or the Qualifying Payment Amount. The benefit is payable to the Non-Non-Contracting provider. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits.

D. Surprise Medical Bills. For information about your rights and protections against surprise medical bills, please visit the following site: https://individual.carefirst.com/individuals-families/mandates-policies/balance-billing.page

13.8 Transitioning of Care from Member's Prior Carrier: Prior Authorization

For Members transitioning care from the Member's immediate prior carrier to CareFirst, At the request of the Member, the Member's parent, guardian or designee, or the Member's provider, CareFirst will accept a prior authorization from the Member's prior carrier for the procedures, treatments, medications or services which are Covered Services and Covered Vision Services under this Evidence of Coverage; and,

A. For the following time period: at least the initial 60 days of an enrollee's coverage under the new health benefits plan

B. At the expiration of the time period stated in 14.11A. of this provision, CareFirst may elect to perform its own utilization review in order to:

1. reassess and make its own determination regarding the need for continued treatment; and

2. authorize any continued procedure, treatment, medication or other Covered Service determined to be Medically Necessary.

13.9 Continuing Treatment with a Non-Preferred Provider Initiated while Covered by the Member's Immediate Prior Carrier:

1. At the request of the Member, the Member's parent, guardian or designee, or the Member's provider, CareFirst will allow a Member to continue to receive Covered Services rendered by a Non-Preferred Provider at the time of the Member's transition to coverage by CareFirst.

2. Continuing treatment with a Non-Preferred Provider pursuant to this provision is limited to:

a) acute conditions that are serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;

b) chronic conditions that are life-threatening, degenerative, potentially disabling, or congenital;

c) a Member who is undergoing inpatient care;

d) a Member who is pregnant and undergoing a course of treatment for the pregnancy from a Non-Preferred Provider;

e) a Member who is scheduled to undergo nonelective surgery from the Non-Preferred Provider, including postoperative care; or

f) is or was determined to be terminally ill and is receiving treatment for the terminal illness from the Non-Preferred Provider.

3. The Member may continue care with the Non-Preferred Provider for the following time periods, ending on the earlier of:

   a) ninety (90) days from the date of notice; or

   b) the date on which the Member is no longer continuing care with the Non-Preferred Provider.

4. For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, CareFirst will treat the services rendered by the Non-Preferred Provider as if the service was provided by a Preferred Provider. The Member is not responsible for the difference between the Allowed Benefit paid to a Preferred Provider and the charge by a Non-Preferred Provider if the Non-Preferred Provider accepts the Allowed Benefit paid to a Preferred Provider as payment in full or the Non-Preferred Provider agrees to an alternative payment amount from CareFirst.

SECTION 14
UTILIZATION MANAGMENT

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.

14.1 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, and/or preadmission testing requirements, concurrent review, and discharge planning.

If coverage is reduced or excluded for failure to comply with utilization management requirements, the reduction or exclusion may be applied to all services related to the treatment, admission, or portion of the admission for which utilization management requirements were not met. The terms that apply to a Member's coverage for failure to comply with utilization management requirements are stated in the Schedule of Benefits.

14.2 Preferred Provider Responsibility

Preferred Providers located in the CareFirst service area are responsible for providing utilization management notices and obtaining necessary utilization management approvals on the Member's behalf. However, the Member must advise the provider that coverage exists under the plan. In addition, the Member must comply with utilization management requirements and determinations. If the Preferred Provider fails to obtain such prior authorization, the Member will be held harmless.

14.3 Member Responsibility

If the Member receives Covered Services outside of the service area, or care is rendered by a Non-Preferred Provider, the Member is responsible for all utilization management requirements.

It is the Member's responsibility to ensure 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.

14.4 Procedures

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

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

14.5 Services Subject to Utilization Management

It is the Member's responsibility to obtain prior authorization for the following services when Covered Services are rendered by Non-Preferred Providers, and for any Covered Services provided outside of the CareFirst service area.

A. Hospital Inpatient Services

All hospitalizations require prior authorization (except for maternity and Emergency admissions as specified). The Member must contact (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.

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

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

C. Organ and Tissue Transplants
Transplants and related services must be coordinated and prior authorization must be obtained from CareFirst. Prior authorization is not required for cornea transplants and kidney transplants. Coverage for related medications is available under Section 10, Prescription Drugs.

D. Ambulance Services. Prior authorization is required for air ambulance services only, except for Medically Necessary air ambulance services in an emergency.

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 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, except Home Health Visits following a Mastectomy and surgical removal of a testicle or post-partum Home Visits;

2. Skilled Nursing Facility Services;

3. Hospice Care Services;

4. Habilitative Services for Adults;

5. Low Vision Services and Medically Necessary Contact Lenses; and

6. Prescription Drugs in the Prescription Drug Guidelines and human growth hormones.

Covered Services not listed in this provision do not require prior authorization. CareFirst reserves the right to make changes to the categories of services that are subject to utilization management requirements or to the procedures the Member and/or the providers must follow. CareFirst will notify the Member of these changes at least forty-five (45) days in advance.

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

14.6 CareFirst Personnel Availability for Prior Authorization
CareFirst will have personnel available to provide prior authorization at all times when prior authorization is required.

14.7 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.

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

SECTION 15
EXCLUSIONS AND LIMITATIONS

15.1 General Exclusions Coverage is not provided for:

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 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:

1. Are furnished without charge; or

2. Are normally furnished without charge to persons without health insurance coverage; or

3. Would have been furnished without charge if a Member were not covered under the Evidence of Coverage or under any health insurance.

This exclusion does not apply to:

a) Medicaid;

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

D. Any service, supply, drug 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 at the discretion of CareFirst. Provision of services by a health care provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.

E. Routine, palliative, or Cosmetic foot care (except for conditions determined to be Medically Necessary at the discretion of CareFirst), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

F. Routine eye examinations and vision services. This exclusion does not apply to evidence-informed preventive care and screenings, including vision care, provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents and as stated in Section 3.

G. Any type of dental care (except treatment of accidental bodily injuries, oral surgery, cleft lip or cleft palate or both, and pediatric dental services), including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess and periodontal disease, removal of teeth, orthodontics, replacement of teeth, or any other dental services or supplies. Benefits for accidental bodily injury are described in Section 1.17. Benefits for oral surgery are described in Section 1.18. Benefits for treatment of cleft lip, cleft palate or both are described in Section 1.19. Benefits for pediatric dental services are described in Section 2. All other procedures involving the teeth or areas and structures

surrounding and/or supporting the teeth, including surgically altering the mandible or maxillae (orthognathic surgery) for Cosmetic purposes or for correction of malocclusion unrelated to a documented 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. All non-Prescription Drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained without a prescription and self-administered by the Member, except as listed as a Covered Service above, including but not limited to: cosmetics or health and beauty aids, 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, except for Over-the-Counter medication or supplies dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

K. Foods or formulas consumed as a sole source of supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.

L. Assisted reproductive technologies that are not listed as a Covered Service, including donor eggs, sperm, and the costs of purchasing/procuring a donor embryo..

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

N. Fees and charges relating to fitness programs, weight loss, or weight control programs, physical or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac Rehabilitation and pulmonary rehabilitation programs are covered as described in Section 1.

O. Maintenance programs for Physical Therapy, Speech Therapy, and Occupational Therapy for those services as stated in Section 1.7; and Cardiac Rehabilitation and pulmonary rehabilitation as stated in Section 1.11C and D.

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

1. Well child care visits for obesity evaluation and management;

2. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);

3. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

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

5. Professional Nutritional Counseling and Medical Nutrition Therapy as described in this Description of Covered Services.

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

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

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. 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 provider.

V. 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.

W. Private duty nursing.

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

1. Telephone consultations, failure to keep a scheduled visit, completion of forms (except for forms that may be required by CareFirst), copying charges or other administrative services provided by the health care provider or the health care provider's staff.

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

Y. Rehabilitation services, including Speech Therapy, Occupational Therapy, or Physical Therapy, for conditions not subject to improvement.

Z. Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

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

BB. 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.

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

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

EE. Custodial Care.

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

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

II. Services required solely for administrative purposes, for example, employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

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

KK. Chiropractic services or spinal manipulation treatment other than spinal manipulation treatment for musculoskeletal conditions of the spine.

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

MM. Benefits will not be provided for Specialty Pharmacy Prescription Drugs obtained from a Pharmacy that is not part of the Exclusive Specialty Pharmacy Network.

NN. Except as otherwise provided, Prescription Drugs not contained in the CareFirst Formulary.

15.2 Pediatric Dental Services

A. Limitations

1. Covered Dental Services must be performed by or under the supervision of a Dentist with an active and unrestricted license, within the scope of practice for which licensure or certification has been obtained.

2. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures including precision attachments and custom denture teeth.

3. If a Member switches from one Dentist to another during a course of treatment, or if more than one Dentist renders services for one dental procedure, CareFirst shall pay as if only one Dentist rendered the service.

4. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).

5. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative procedure.

B. Exclusions
Benefits will not be provided for:

1. Replacement of a denture or crown as a result of loss or theft.

2. Replacement of an existing denture or crown that is determined by CareFirst to be satisfactory or repairable.

3. Replacement of dentures, implants, metal and/or porcelain crowns, inlays, onlays, pontics and crown build-ups within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of this Description of Covered Services and are judged by CareFirst to be adequate and functional.

4. Gold foil fillings.

5. Periodontal appliances.

6. Oral orthotic appliances, unless specifically listed as a Covered Dental Service.

7. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service.

8. Intentional tooth reimplantation or transplantation.

9. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.

10. Additional fees charged for visits by a Dentist to the Member's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the Dentist’s office during normal office hours.

11. Transseptal fiberotomy.

12. Orthognathic Surgery.

13. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service.

14. Any orthodontic services after the last day of the month in which Covered Dental Services ended.

15. Separate billings for dental care services or supplies furnished by an employee of a Dentist which are normally included in the Dentist’s charges and billed for by them.

16. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.

17. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.

18. Provision splinting, intracoronal and extracoronal.

19. Endodontic implant.

20. Fabrication of athletic mouthguard.

21. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

22. Adjustments to maxillofacial prosthetic appliance.

23. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral).

24. Any orthodontic services after the last day of the calendar year in which the Member turned age 19.

15.3 Pediatric Vision Services

Benefits will not be provided for the following:

A. Any pediatric vision service stated in Section 3 for Members over age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive covered pediatric vision services through the rest of that Calendar Year.

B. Diagnostic services, except as listed in Section 3.

C. Services or supplies not specifically approved by the Vision Care Designee where required in this Description of Covered Services.

D. Orthoptics, vision training, and low vision aids.

E. Non-prescription (Plano) lenses and/or glasses, sunglasses or contact lenses.

F. Except as otherwise provided, Vision Care services that are strictly Cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

G. Services and materials not meeting accepted standards of optometric practice.

H. Services and materials resulting from the Member's failure to comply with professionally prescribed treatment.

I. Office infection control charges.

J. State or territorial taxes on vision services performed.

K. Special lens designs or coatings other than those described herein.

L. Replacement of lost and/or stolen eyewear.

M. Two pairs of eyeglasses in lieu of bifocals.

N. Insurance of contact lenses.

15.4 Organ and Tissue Transplants

A. Limitations.

1. Lodging at a hotel or similar setting is limited to $50 per day per Member eligible for the travel cost benefit.

2. Covered transportation costs are limited to ground and/or air travel reimbursement.

a. Ground transportation includes personal vehicle (mileage), parking and tolls, taxis, ride share services, metro bus, train, and shuttle services.

b. Air transportation via commercial flight is limited to coach class only, including reasonable baggage and seating selection fees.

c. Train and bus ticket fares are limited to coach class.

B. Benefits will not be provided for the following:

1. 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 this In-Network Description of Covered Services.

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

3. Any charges related to meals, tobacco, alcohol, drugs, phone charges, television, recreation, personal expenses, business or first-class airfare, extra legroom seating; priority boarding, rental cars, Limousine, and private car services, gas; and expenses reimbursed by another source (e.g., employer, non-profits, etc.)

4. Transportation and travel expenses (except for Medically Necessary air and ground ambulance services, as determined by CareFirst, and services listed under Section 1.13, Organ and Tissue Transplants, of this In-Network Description of Covered Services), whether or not recommended by a health care provider.

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

6. Donor search services.

7. Any service, supply, or device related to a transplant that is not listed as a benefit in this In-Network Description of Covered Services.

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

15.5 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 that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private duty nursing.

15.6 Home Health Care Services Coverage is not provided for:

A. Custodial Care.

B. Private duty nursing.

15.7 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.

H. Meals on Wheels or other similar food service arrangements.

I. Rental or purchase of renal dialysis equipment and supplies. Benefits for dialysis equipment and supplies are available in Section 10, Medical Devices and Supplies.

15.8 Outpatient Mental Health and Substance Use Disorder Coverage is not provided for:

A. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director.

B. Intellectual disability, after diagnosis.

C. Psychoanalysis.

15.9 Inpatient Mental Health and Substance Use Disorder Coverage is not provided for:

A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director.

B. Custodial Care.

C. Admissions solely for observation or isolation.

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

A. Convenience Items

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, appliances, or hearing aids (except as otherwise provided herein for cleft lip or cleft palate or both or as stated in Section 2 and Section 3).

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

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

I. Tinnitus maskers.

15.11 Prescription Drugs

Benefits will not be provided for the following:

A. Except where otherwise provided, Prescription Drugs not included on the Formulary.

B. Specialty Drugs obtained from a Pharmacy that is not part of the Exclusive Specialty Pharmacy Network.

C. Any devices, appliances, supplies, and equipment except as otherwise noted.

D. Routine immunizations and boosters for foreign travel.

E. Prescription Drugs for cosmetic use.

F. Except where otherwise provided, Prescription Drugs administered by a physician or dispensed in a physician's office.

G. Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst.

H. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.

I. Vitamins, except CareFirst will provide a benefit for Prescription Drugs:

1. Prenatal vitamins.

    1. Fluoride and fluoride containing vitamins.

    2. Single entity vitamins, such as Rocaltrol and DHT.

    3. Vitamins included on the Preventive Drug List.

J. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Description of Covered Services.

K. Any portion of a Prescription Drug that exceeds:

    1. a thirty (30) day supply for Prescription Drugs;

2. up to a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst; or,

3. up to a twelve (12) month supply of prescription contraceptives.

L. Except where otherwise provided, 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.

M. Prescription Drugs for weight loss.

N. Biologicals, except where otherwise provided, and allergy extracts.

O. Blood and blood products. May be covered under the medical benefits in this Description of Covered Services

Group Hospitalization and Medical Services, Inc.

doing business as

CareFirst BlueCross BlueShield (CareFirst)

840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

INTER-PLAN ARRANGEMENTS DISCLOSURE AMENDMENT

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

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

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

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

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

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

C. Non-participating Providers Outside CareFirst Service Area

1. Member Liability Calculation

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

2. Exceptions

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

D. Blue Cross Blue Shield Global® Core

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

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

- **Inpatient Services**

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

- **Outpatient Services**

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

- **Submitting a Blue Cross Blue Shield Global® Core Claim**

  When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from CareFirst, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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

Group Hospitalization and Medical Services, Inc.

[Signature.**]**

_____

[Name.**]**
[Title.**]**

Group Hospitalization and Medical Services, Inc.

doing business as
CareFirst BlueCross BlueShield
1440 G Street, NW
Washington, DC 20005
(202) 479-8000

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT C SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Evidence of Coverage.

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

Deductible

General Cost Share & Features	In Network	Out of Network
Deductible: - Per Benefit Period - Medical only - Some services do not apply to the Deductible, as indicated below.	$1,300/Individual $2,600/Family	$2,600/Individual $5,200/Family

Individual Coverage: The Member must satisfy 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 In-Network Deductible and the Out-of-Network Deductible are separate amounts and do not contribute to one another. Amounts paid by the Member for In-Network Covered Services apply to the In-Network Deductible, except as indicated below. Amounts paid by the Member for Out-of-Network Covered Services apply to the Out-of-Network Deductible, except as indicated below.

The following amounts may <u>not</u> be used to satisfy the In-Network OR Out-of-Network Deductibles:

- Amounts incurred for failure to comply with the utilization management program requirements.
- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.
- Charges in excess of the Allowed Benefit and Prescription Drug Allowed Benefit.
- Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days listed below.
- Copayments or Coinsurance for Covered Services and Covered Prescription Drugs not subject to the Deductible.
- Copayments or Coinsurance for Covered Pediatric Vision Services or Covered Pediatric Dental Services.

The benefit chart below states whether a covered service is subject to a Deductible. If a Deductible applies, the chart will also state whether a Deductible applies to In-Network benefits, Out-of-Network benefits, or both.

Out-of-Pocket Maximum

General Cost Share & Features	In Network	Out of Network
Out-of-Pocket Maximum: - Per Benefit Period - Medical and Drug Combined	$9,900/Individual $19,800/Family	$19,800/Individual $39,600/Family
	The following amounts apply to the In-Network Out-of-Pocket Maximum: • Copayments for In-Network services. • Coinsurance for covered In-Network services, including In-Network Pediatric Dental Services. • Copayment, Coinsurance, and Deductible payments for essential health benefits provided by an Out-of-Network ancillary provider in an In-Network setting, as provided by 45 CFR § 156.230. • The In-Network Deductible. • Charges for Prescription Drugs. When the Member has reached the In-Network Out-of-Pocket Maximum, no further Copayments, Coinsurance, or Deductibles will be required in that Benefit Period for In-Network services.	**The following amounts apply to the Out-of-Network Out-of-Pocket Maximum:** • Copayments and Coinsurance for covered Out-of-Network services, including Out-of-Network Pediatric Dental Services. Amounts paid for Covered Prescription Drugs obtained from a non- Contracting Pharmacy Provider will be applied to the In-Network Out-of-Pocket Maximum. • The Out-of-Network Deductible. When the Member has reached the Out-of-Network Out-of-Pocket Maximum, no further Copayments, Coinsurance, or Deductibles will be required in that Benefit Period for Out-of-Network services.

Individual Coverage: The Member must meet the Individual Out-of-Pocket Maximum.

Family Coverage: Each Member can satisfy his/her own Individual Out-of-Pocket Maximum by meeting the Individual Out-of-Pocket Maximum. In addition, eligible expenses of all covered family members can be combined to satisfy the Family Out-of-Pocket Maximum. An individual family member cannot contribute more than the Individual Out-of-Pocket

Maximum toward meeting the Family Out-of-Pocket Maximum. Once the Family Out-of- Pocket Maximum has been met, this will satisfy the Out-of-Pocket Maximum for all family members.

The In-Network Out-of-Pocket Maximum and the Out-of-Network Out-of-Pocket Maximum are separate amounts and do not contribute to one another.

The following amounts may <u>not</u> be used to meet the In-Network or Out-of-Network Out-of-Pocket Maximum:

- Amounts incurred for failure to comply with the utilization management program requirements.
- Charges in excess of the Allowed Benefit, Prescription Drug Allowed Benefit, Vision Allowed Benefit and Pediatric Dental Allowed Benefit.
- Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days listed below.
- Charges for Out-of-Network Covered Pediatric Vision Services.
- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available. If a Member selects a Brand Name Drug when a Generic Drug is available, manufacturer coupons and the difference between the price of the Brand Name Drug and the Generic Drug would not count towards the Out-of-Pocket Maximum. If the Brand Name Drug does not have a Generic Drug equivalent, then manufacturer coupons may count towards the Out-of-Pocket Maximum.

UTILIZATION MANAGEMENT

Failure or refusal to comply with utilization management program requirements will result in a 50% reduction in benefits for services associated with the Member's care or treatment (other than Medically Necessary inpatient Ancillary Services and Prescription Drug, Pediatric Vision and Pediatric Dental benefits).

Benefits

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. **See Prior Authorization Amendment for Covered Services that require prior authorization.** **The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.**				
When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider. **Important Information Regarding Facility Fee(s):** The benefit chart below states whether a Covered Service is subject to the Member Copayment or Coinsurance for Clinic Visits/Outpatient Services rendered in a hospital, hospital clinic, or health care provider's office on a hospital campus ("Clinic Visit"). These providers may bill individually resulting in claims from both the hospital/facility and the physician or health care provider rendering care in the hospital/facility/clinic setting. It is the Member's responsibility to determine whether separate claims will be assessed.				
SELECTED PROVIDER SERVICES				
Physician's Office or Virtual Care • The Deductible is waived and there is no Copayment or Coinsurance for covered in-person or Virtual Care preventive, PCP office visits, and mental health and Substance Use Disorder office visits provided by Selected Providers including Virtual Connect Providers. • Specialist services provided by Selected Providers will pay to the same extent as Specialists and Professional Services in the benefit chart below. • Coverage by a Selected Provider in-person or via Virtual Care office visits are limited to services available by the Selected Provider. • For Covered Services with visit limitations, these visit limitations will apply to the Selected Provider(s). • For Covered Services not provided by a Selected Provider, the Deductible, Copayment, or Coinsurance will pay as shown in the benefit chart below.				
OUTPATIENT FACILITY, OFFICE, AND PROFESSIONAL SERVICES				
Physician's Office	Services rendered by Specialists in the disciplines listed below will be treated as PCP visits for Member payment purposes. • General internal medicine • Family practice medicine • General pediatric medicine, or • Geriatric medicine.	PCP: Out-of-Network Specialist: Out-of-Network Clinic Visit: In-Network and Out-of-Network	PCP: $15 per visit Specialist: $40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	PCP: $50 per visit Specialist: $50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Outpatient Non-Surgical Services		PCP: Out-of-Network Specialist: Out-of-Network Clinic Visit: In-Network and Out-of-Network	PCP: $15 per visit Specialist: $40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	PCP: $50 per visit Specialist: $50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Laboratory Tests, X-Ray/Radiology Services, Specialty Imaging, and Diagnostic Procedures				
Non-Preventive Laboratory Tests (independent non-hospital laboratory)		Out-of-Network	$15 per visit	$65 per visit
Non-Preventive Laboratory Tests (outpatient department of a hospital)		In-Network and Out-of-Network	$60 per visit	$110 per visit
Non-Preventive X-Ray/Radiology Services (independent non-hospital facility)		Out-of-Network	$30 per visit	$80 per visit
Non-Preventive X-Ray/Radiology Services (outpatient department of a hospital)		In-Network and Out-of-Network	$75 per visit	$110 per visit
Non-Preventive Specialty Imaging (independent non-hospital facility)		Out-of-Network	$200 per visit	$250 per visit
Non-Preventive Specialty Imaging (outpatient department of a hospital)		In-Network and Out-of-Network	$400 per visit	$450 per visit
Non-Preventive Diagnostic Testing except as otherwise specified (in an independent non-hospital facility)		Out-of-Network	$30 per visit	$80 per visit

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Non-Preventive Diagnostic Testing except as otherwise specified (in an outpatient department of a hospital)		In-Network and Out-of-Network	$75 per visit	$110 per visit
Sleep Studies-Member's Home		Out-of-Network	$40 per study	$50 per study
Sleep Studies-Physician's Office		Out-of-Network	$40 per study	$50 per study
Sleep Studies-Free-Standing Facility		Out-of-Network	$40 per study	$50 per study
Sleep Studies-Outpatient Department of a Hospital		In-Network and Out-of-Network	$400 per study	$500 per study
Preventive Care – Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society or required by the Patient Protection and Affordable Care Act (PPACA) as well as 3-D mammogram and adjuvant breast cancer screening, as described in the Description of Covered Services.				
Prostate Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Colorectal Cancer Screening		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Breast Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Pap Smear		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Human Papillomavirus Screening Test		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Laboratory Tests		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive X-Ray/Radiology Services		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Specialty Imaging		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Diagnostic Testing (except as otherwise specified)		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Immunizations		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Well Child Care		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Adult Preventive Care		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Women's Preventive Services		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Office Visits for Treatment of Obesity		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Professional Nutritional Counseling and Medical Nutrition Therapy		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
TREATMENT SERVICES				
Family Planning				
Non-Preventive Gynecological Office Visits		PCP: Out-of-Network Specialist: Out-of-Network Clinic Visit: In-Network and Out-of-Network	PCP: $15 per visit Specialist: $40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	PCP: $50 per visit Specialist: $50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Contraceptive Counseling		Professional: Out-of-Network Clinic Visit: Out-of-Network	No Copayment or Coinsurance	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Contraceptive Drugs and Devices	Coverage of self-administered contraceptive drugs and devices is provided under the Prescription Drugs benefit.	Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs	Drug or device must be approved by the FDA as a contraceptive.	Professional: Out-of-Network Clinic Visit: Out-of-Network	No Copayment or Coinsurance	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Elective Sterilization Services - Female Members (includes consultation, procedure, and follow-up visit related to a voluntary sterilization)	Benefits available to female Members with reproductive capacity only.	No	No Copayment or Coinsurance	No Copayment or Coinsurance
Elective Sterilization Reversal Services - Female Members (includes consultation, procedure, and follow-up visit related to a voluntary sterilization)		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Elective Sterilization Services - Male Members (includes consultation, procedure, and follow-up visit related to a voluntary sterilization)		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Elective Sterilization Reversal services - Male Members (includes consultation, procedure, and follow-up visit related to a voluntary sterilization)		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Maternity and Related Services				
Preventive Visit		Out-of-Network	No Copayment or Coinsurance	$50 per visit

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Non-Preventive Visit		Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Professional Services for Delivery		In-Network and Out-of-Network	$40 per visit	$50 per visit
Infertility Treatment				
Infertility Counseling and Testing		Benefits are paid at the same extent as other counseling and testing services		
Artificial & Intrauterine Insemination and other infertility treatments		Benefits are available to the same extent as benefits provided for other services		
In Vitro Fertilization		Benefits are available to the same extent as benefits provided for other services		
Allergy Services				
Allergy Testing and Allergy Treatment		Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Allergy Shots		Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Rehabilitation Services				
Rehabilitative Physical Therapy		Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Rehabilitative Occupational Therapy		Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Rehabilitative Speech Therapy		Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Spinal Manipulation Services		Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
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Habilitative Services for Children	Limited to Members until the end of the month in which the Member turns 21 years old.	Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Habilitative Services for Adults	Benefits are available to Members on the first day of the month after the Member turns age 21.	Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Applied Behavioral Analysis Therapy		Out-of-Network	$15 per visit	$50 per visit
Acupuncture		Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Cardiac Rehabilitation	Limited to 90 days per therapy per Benefit Period.	Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Pulmonary Rehabilitation	Limited to one pulmonary rehabilitation program per lifetime.	Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Other Treatment Services				
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation, pulmonary rehabilitation and Infusion Services)		Professional: Out-of-Network Clinic Visit: In-Network and Out-of-Network	$40 per visit **and** $50 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility	$50 per visit **and** $150 per visit (Facility) **if** rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **and** there is a separate claim for the hospital/facility
Blood and Blood Products		Benefits are available to the same extent as benefits provided for other infusion services		
Controlled Clinical Trial		Benefits are available to the same extent as benefits provided for other services		
Retail Health Clinic		Out-of-Network	$15 per visit	$50 per visit
Telemedicine Services		Benefits are available to the same extent as benefits provided for other services		
Infusion Therapy-Member's Home		Out-of-Network	$40 per session	$50 per session
Infusion Therapy-Physician's Office		Out-of-Network	$40 per session	$50 per session
Infusion Therapy-Free-Standing Infusion Center		Out-of-Network	$40 per session	$50 per session
Infusion Therapy-Hospital Outpatient Department		In-Network and Out-of-Network	$400 per session	$500 per session
Outpatient Surgical Facility and Professional Services				
Surgical Care at an Ambulatory Care Facility		Out-of-Network	$300 per visit	$400 per visit

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Outpatient Surgical Professional Services Provided at an Ambulatory Care Facility	Routine/Screening Colonoscopy is not subject to the In-Network Copayment and Deductible.	Out-of-Network	$40 per visit	$50 per visit
Surgical Care at an Outpatient Hospital Facility		In-Network and Out-of-Network	$400 per visit	$500 per visit
Outpatient Surgical Professional Services Provided at an Outpatient Hospital	Routine/Screening Colonoscopy is not subject to the In-Network Copayment and Deductible.	In-Network and Out-of-Network	$40 per visit	$50 per visit
INPATIENT HOSPITAL SERVICES				
Inpatient Facility (medical or surgical condition, including maternity and rehabilitation)	Hospitalization solely for Rehabilitation limited to ninety (90) days per Benefit Period.	In-Network and Out-of-Network	$500 per admission	$600 per admission
Inpatient Professional Services		In-Network and Out-of-Network	$40 per visit	$50 per visit
Organ and Tissue Transplants		Benefits are available to the same extent as benefits provided for other services		
SKILLED NURSING FACILITY SERVICES				
Skilled Nursing Facility Services	Limited to 60 days per Benefit Period.	In-Network and Out-of-Network	$500 per admission	$600 per admission
HOME HEALTH SERVICES				
Home Health Services	Limited to 90 visits per episode of care A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for sixty (60) consecutive days.	Out-of-Network	No Copayment or Coinsurance	$50 per visit
Postpartum Home Visits	Benefits are available to all Members.	No	No Copayment or Coinsurance	No Copayment or Coinsurance
HOSPICE SERVICES				
Inpatient Care	Services limited to a maximum one hundred eighty (180) day hospice eligibility period. Limited to sixty (60) days per hospice eligibility period.	Out-of-Network	No Copayment or Coinsurance	$50 per admission

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Outpatient Care	Services limited to a maximum one hundred eighty (180) day hospice eligibility period.	Out-of-Network	No Copayment or Coinsurance	$50 per visit
Respite Care	Services limited to a maximum one hundred eighty (180) day hospice eligibility period.	Out-of-Network	No Copayment or Coinsurance	$50 per visit
Bereavement Services	Services limited to the six (6) month period following the Member's death or fifteen (15) visits, whichever occurs first.	Out-of-Network	No Copayment or Coinsurance	$50 per visit
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES				
Outpatient Services				
Office Visits		Out-of-Network	$15 per visit	$50 per visit
Outpatient Hospital Facility Services		Out-of-Network	$50 per visit	$50 per visit
Outpatient Professional Services Provided at an Outpatient Hospital Facility		Out-of-Network	$30 per visit	$50 per visit
Outpatient Psychological and Neuro-psychological Testing for Diagnostic Purposes		Out-of-Network	$15 per visit	$50 per visit
Methadone Maintenance		Out-of-Network	$15 per visit	$50 per visit
Partial Hospitalization Facility		Out-of-Network	$50 per visit	$50 per visit
Professional Services at a Partial Hospitalization Facility		Out-of-Network	$30 per visit	$50 per visit
Inpatient Services				
Inpatient Facility Services		In-Network and Out-of-Network	$500 per admission	$600 per admission
Inpatient Professional Services		In-Network and Out-of-Network	$40 per visit	$50 per visit
EMERGENCY SERVICES AND URGENT CARE				
Urgent Care Facility	Limited to unexpected, urgently required services.	Out-of-Network	$50 per visit	$150 per visit

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Hospital Emergency Room - Facility Services	Limited to Emergency Services.	In-Network and Out-of-Network benefit subject to In-Network Deductible	$500 per visit (waived if admitted)	Covered as In-Network
Hospital Emergency Room - Professional Services	Limited to Emergency Services.	In-Network and Out-of-Network benefit subject to In-Network Deductible	$40 per visit	Covered as In-Network
Ambulance Service		In-Network and Out-of-Network benefit subject to In-Network Deductible	$40 per visit	Covered as In-Network
MEDICAL DEVICES AND SUPPLIES				
Durable Medical Equipment		In-Network and Out-of-Network	25% of the Allowed Benefit	45% of the Allowed Benefit
Hair Prosthesis	Limited to one per Benefit Period.	In-Network and Out-of-Network	25% of the Allowed Benefit	45% of the Allowed Benefit
Breastfeeding Equipment and Supplies		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit

SERVICE	LIMITATIONS (COMBINED IN-NETWORK AND OUT-OF-NETWORK)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Member is responsible for any applicable Deductible, Copayment, or Coinsurance listed in this schedule. When the Allowed Benefit for any Covered Service is less than the Copayment listed, the Member payment will be the Allowed Benefit. See Prior Authorization Amendment for Covered Services that require prior authorization. The Deductible and Copayments or Coinsurance will be waived for covered services by a Selected Provider. This excludes Specialist benefits for which benefits are paid to the same extent as other services below.				
Diabetes Equipment	Coverage for Diabetic Supplies will be provided under the Prescription Drug benefit.	In-Network and Out-of-Network, except as provided below. The In-Network and Out-of-Network Deductibles will be waived and the cost share will not exceed $100 for covered Diabetic Equipment used to diagnose, mitigate, or prevent diabetes, or to screen for diabetic ketoacidosis in individuals diagnosed with diabetes. Any cost sharing prior to meeting the In-Network and Out-of-Network Deductibles will be applied towards the In-Network and Out-of-Network Deductibles.	25% of the Allowed Benefit	45% of the Allowed Benefit

Contraceptive/Prescription Drugs

Drug Deductible

Drug Cost Share & Features	In-Network	Out-of-Network
Deductible - Per Benefit Period Drug Only	$250 per Person	Not Applicable

The following amounts may <u>not</u> be used to satisfy the Prescription Drug Deductible:

- Copayments or Coinsurance for Covered Prescription Drugs not subject to Deductible.

The following amounts may be used to satisfy the Prescription Drug Deductible:

- Copayments or Coinsurance for Covered Prescription Drugs subject to Deductible.

Drug Out-of-Pocket Maximum (OOPM)

Drug Cost Share & Features	In-Network	Out-of-Network
Maximum Out of Pocket - Per Benefit Period Drug Only	Integrated with Medical OOPM	Not Applicable

Contraceptive/Prescription Drug Benefits

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE?	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment or Coinsurance when Medically Necessary, as determined by CareFirst. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. • Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible stated in this Schedule of Benefits. • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment or Coinsurance. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines. • Any cost sharing paid by the member for prescription insulin drugs will be applied to the patient's deductible. • Select Generic drugs are certain generic drugs used to treat specific chronic conditions that are recognized by the Internal Revenue Service as preventive care. Select Generic drugs are included on the CareFirst Preventive Drug List.				
Preventive Drugs	Limited to a thirty (30)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Oral Chemotherapy Drugs	Limited to a thirty (30)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Diabetic Supplies	Limited to a thirty (30)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Preferred Brand Name Insulin	Limited to a thirty (30)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Opioid Reversal Agents	Limited to a thirty (30)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Select Generic Drugs	Limited to a thirty (30)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Generic Drugs	Limited to a thirty (30)-day supply per prescription or refill.	No	$10 per prescription or refill	
Preferred Brand Name Drugs	Limited to a thirty (30)-day supply per prescription or refill.	Yes	$45 per prescription or refill	
Non-Preferred Brand Name Drugs	Limited to a thirty (30)-day supply per prescription or refill.	Yes	$70 per prescription or refill	

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE?	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment or Coinsurance when Medically Necessary, as determined by CareFirst. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. • Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible stated in this Schedule of Benefits. • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment or Coinsurance. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines. • Any cost sharing paid by the member for prescription insulin drugs will be applied to the patient's deductible. • Select Generic drugs are certain generic drugs used to treat specific chronic conditions that are recognized by the Internal Revenue Service as preventive care. Select Generic drugs are included on the CareFirst Preventive Drug List.				
Non-Preferred Brand Name Insulin	Limited to a thirty (30)-day supply per prescription or refill.	No	$30 per prescription or refill	
Maintenance Drugs– Maintenance Drug means a Covered Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.				
Preventive Drugs	Limited to a ninety (90)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Oral Chemotherapy Drugs	Limited to a ninety (90)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Diabetic Supplies	Limited to a ninety (90)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Preferred Brand Name Insulin	Limited to a ninety (90)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Opioid Reversal Agents	Limited to a ninety (90)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Select Generic Drugs	Limited to a ninety (90)-day supply per prescription or refill.	No	No Copayment or Coinsurance	
Generic Drugs	Limited to a ninety (90)-day supply per prescription or refill.	No	$20 per prescription or refill	
Preferred Brand Name Drugs	Limited to a ninety (90)-day supply per prescription or refill.	Yes	$90 per prescription or refill	
Non-Preferred Brand Name Drugs	Limited to a ninety (90)-day supply per prescription or refill.	Yes	$140 per prescription or refill	

SERVICE	LIMITATIONS	SUBJECT TO PRESCRIPTION DRUG DEDUCTIBLE?	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment or Coinsurance when Medically Necessary, as determined by CareFirst. • A Member may request a Non-Preferred Brand Name Drug be covered for the Preferred Brand Name Drug Copayment if the provider determines that the Preferred Brand Name Drug would not be effective or would result in adverse effects. • Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Prescription Drug Deductible stated in this Schedule of Benefits. • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment or Coinsurance. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines. • Any cost sharing paid by the member for prescription insulin drugs will be applied to the patient's deductible. • Select Generic drugs are certain generic drugs used to treat specific chronic conditions that are recognized by the Internal Revenue Service as preventive care. Select Generic drugs are included on the CareFirst Preventive Drug List.				
Non-Preferred Brand Name Insulin	Limited to a ninety (90)-day supply per prescription or refill.	No	$60 per prescription or refill	
Specialty Drugs Benefits for Covered Specialty Drugs are only available when Covered Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network. Coverage for Specialty Drugs will **not** be provided when a Member purchases Covered Specialty Drugs from a Pharmacy **outside** of the Exclusive Specialty Pharmacy Network.				
Specialty Drugs – 30-day Supply				
Preferred Specialty Drugs	Limited to a thirty (30)-day supply per prescription or refill.	Yes	50% of the Prescription Drug Allowed Benefit per prescription or refill up to a $100 member maximum payment	
Non-Preferred Specialty Drugs	Limited to a thirty (30)-day supply per prescription or refill.	Yes	50% of the Prescription Drug Allowed Benefit per prescription or refill up to a $150 member maximum payment	
Specialty Drugs – 90-day Supply				
Preferred Specialty Drugs	Limited to a ninety (90)-day supply per prescription or refill.	Yes	50% of the Prescription Drug Allowed Benefit per prescription or refill up to a $200 member maximum payment	
Non-Preferred Specialty Drugs	Limited to a ninety (90)-day supply per prescription or refill.	Yes	50% of the Prescription Drug Allowed Benefit per prescription or refill up to a $300 member maximum payment	

Vision Deductible

Vision Cost Share & Features	In-Network	Out-of-Network
Deductible - Per Benefit Period	Not Applicable	Not Applicable

Vision Out-of-Pocket Maximum (OOPM)

Vision Cost Share & Features	In-Network	Out-of-Network
Out-of-Pocket Maximum - Per Benefit Period	Not Applicable	Not Applicable

Pediatric Vision Benefits

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			CONTRACTING VISION PROVIDER	NON-CONTRACTING VISION PROVIDER
Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.				
Eye Examination	Limited to one per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $40 are a non-Covered Vision Service.
Lenses - Important note regarding Member Payments: "Basic" means spectacle lenses with no "add-ons" such as, glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses and others which may result in additional costs to the Member.				
Basic Single Vision	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $40 are a non-Covered Vision Service.
Basic Bifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $60 are a non-Covered Vision Service.
Basic Trifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $80 are a non-Covered Vision Service.
Basic Lenticular	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $80 are a non-Covered Vision Service.

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			CONTRACTING VISION PROVIDER	NON-CONTRACTING VISION PROVIDER
Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.				
Frames				
Frames	Limited to one frame per Benefit Period. Services rendered by Contracting Vision Providers limited to frames contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $70 are a non-Covered Vision Service.
Low Vision				
Low Vision Eye Examination	Limited to one comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5 year period.	No	Expenses in excess of the Vision Allowed Benefit of $300 are a non-Covered Vision Service.	Expenses in excess of the Vision Allowed Benefit of $300 are a non-Covered Vision Service.
Follow-up care	Limited to 4 visits in any five-year period.	No	Expenses in excess of the Vision Allowed Benefit of $100 are a non-Covered Vision Service.	Expenses in excess of the Vision Allowed Benefit of $100 are a non-Covered Vision Service.
High-power Spectacles, Magnifiers and Telescopes		No	Expenses in excess of the Vision Allowed Benefit of $600 are a non-Covered Vision Service.	Expenses in excess of the Vision Allowed Benefit of $600 are a non-Covered Vision Service.
Contact Lenses				
Elective	Limited to one pair per Benefit Period or multiple pairs of disposable contact lenses per Benefit Period. Includes evaluation, fitting and follow-up fees. Services rendered by Contracting Vision Providers limited to contact lenses contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $105 are a non-Covered Vision Service.
Medically Necessary	Limited to one pair per Benefit Period or multiple pairs of disposable contact lenses per Benefit Period. Includes evaluation, fitting and follow-up fees.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $240 are a non-Covered Vision Service.

Pediatric Dental Deductible

Dental Cost Share & Features	In-Network	Out-of-Network
Deductible - Per Benefit Period - Applies to all Class II, III, and IV Covered Dental Services.	$25 per Member	$50 per Member

The In-Network Pediatric Dental Deductible and the Out-of-Network Pediatric Dental Deductible are separate amounts and do not contribute to one another.

The following amounts may <u>not</u> be used to satisfy the Pediatric Dental Deductible:

- Copayments or Coinsurance for Covered Pediatric Dental services

Pediatric Dental Out-of-Pocket Maximum (OOPM)

Dental Cost Share & Features	In-Network	Out-of-Network
Out-of-Pocket Maximum - Per Benefit Period	Amounts paid by the Member for Covered Pediatric Dental Services will be applied to the Out-of-Pocket Maximum stated in this Schedule of Benefits. Once the Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible or Coinsurance.	Not Applicable

Pediatric Dental Benefits

SERVICE	LIMITATIONS	SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED DENTIST	NON-PREFERRED DENTIST
Pediatric Dental – Limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Dental Services up to the end of the Calendar Year in which the Member turns age 19.				
Class I Preventive & Diagnostic Services		No	No Copayment or Coinsurance	20% of the Pediatric Dental Allowed Benefit
Class II Basic Services		Yes	20% of the Pediatric Dental Allowed Benefit	40% of the Pediatric Dental Allowed Benefit
Class III Major Services – Surgical		Yes	20% of the Pediatric Dental Allowed Benefit	40% of the Pediatric Dental Allowed Benefit
Class IV Major Services – Restorative		Yes	50% of the Pediatric Dental Allowed Benefit	65% of the Pediatric Dental Allowed Benefit
Class V Orthodontic Services	Limited to Medically Necessary Orthodontia.	No	50% of the Pediatric Dental Allowed Benefit	65% of the Pediatric Dental Allowed Benefit

Group Hospitalization and Medical Services, Inc.
[Signature]

[Name]
[Title]

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

An independent licensee of the Blue Cross and Blue Shield Association

INTER-PLAN PROGRAM ANCILLARY SERVICES AMENDMENT

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

As used in this amendment, "Out-of-Area Covered Ancillary Services" mean:

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

Under the BlueCard® Program, Members are able to obtain Covered Ancillary Services outside the geographic area that CareFirst services. This program allows Members to obtain Out-of-Area Covered Ancillary Services from providers that have a contractual agreement (i.e., are "participating providers" or "contracted providers") with the local Blue Cross and/or Blue Shield Licensee in another geographic area, as well as non-participating providers in some instances.

As used in this amendment, the "Local Plan" means the plan that is responsible for processing Out-of-Area Covered Ancillary Services claims under the BlueCard® Program.

Member payment for Out-of-Area Covered Ancillary Services at the participating or non-participating provider payment level is determined by the relationship between the provider and the Local Plan. If the provider of Covered Ancillary Services has a contract with the Local Plan (a participating provider), the Member is responsible for the participating provider member payment as stated in the Inter-Plan Arrangements Disclosure Amendment.

If the provider of Covered Ancillary Services does not have a contract with the Local Plan (a non-participating provider), the Member is responsible for the non-participating provider member payment as stated in the Inter-Plan Arrangements Disclosure Amendment.

For Out-of-Area Covered Ancillary Services, the Local Plan is determined as follows:

Independent Clinical Laboratory Tests - if the referring provider is located in the same service area where the specimen was drawn, the plan of the service area where the specimen was drawn is the Local Plan; if the referring provider is not located in the same service area where the specimen was drawn, the plan of the service area where the referring provider is located is the Local Plan.

Medical Devices and Supplies - the plan of the service area where the equipment was shipped to or purchased at a retail store is the Local Plan.

Specialty Prescription Drugs - the plan of the service area where the ordering physician is located is the Local Plan.

This amendment is subject to all of the terms and conditions of the Evidence of Coverage to which it is attached and does not change any terms or conditions, except as specifically stated herein.

Group Hospitalization and Medical Services, Inc.

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MEDICAL FOODS TREATMENT AMENDMENT

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

The Medical Foods and Low Protein Modified Food Products provision of the Description of Covered Services is deleted and replaced with the following:

> Medical Foods and Low Protein Modified Food Products are covered if the Medical Foods or Low Protein Modified Food Products are:
>
> 1. Prescribed as Medically Necessary for therapeutic treatment of:
>   i. Inflammatory bowel disease, including Crohn's disease, ulcerative colitis, and indeterminate colitis;
>   ii. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
>   iii. Immunoglobulin E- and non-Immunoglobulin E-mediated allergies to food proteins;
>   iv. Food protein-induced enterocolitis syndrome;
>   v. Eosinophilic disorders, including eosinophilic esophagitis, eosinophilic gastroenteritis, eosinophilic colitis, and post-transplant eosinophilic disorders;
>   vi. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract, including short bowel syndrome and chronic intestinal pseudo-obstruction;
>   vii. Malabsorption due to liver or pancreatic disease; or
>   viii. Inherited metabolic disorders; and
> 2. Administered under the direction of a physician.

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]

_____

[Name]
[Title]

Group Hospitalization and Medical Services, Inc.
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PRIOR AUTHORIZATION AMENDMENT

This amendment is effective _____. If no date is shown, this amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

All references to prior authorization requirements for medical services only in the Description of Covered Services are deleted.

Section 14.5, Services Subject to Utilization Management, in the Description of Covered Services is deleted and replaced with the following

14.5 Services Subject to Utilization Management

A. CareFirst requires prior authorization for certain diagnostics and medical treatment. When a Member seeks services from a Preferred Provider, the Preferred Provider is responsible for obtaining necessary utilization management approvals on the Member's behalf for services that require prior authorization. If the Preferred Provider fails to obtain prior authorization for Covered Services, there is no benefit for the Service, and the Member shall be held harmless. For services that require prior authorization obtained from a Preferred Provider, prior authorization will not be generated retroactively.

It is the Member's responsibility to obtain prior authorization when services are rendered outside of the CareFirst Service Area and for services rendered by Non-Preferred Providers. Failure to obtain authorization from CareFirst may result in reduction or denial of coverage.

B. Services Requiring Prior Authorization. Medical treatment received under the following categories of services may require prior authorization:

1. Hospital Inpatient Services.
2. Inpatient Mental Health and Substance Use Disorder Services admissions.
3. Inpatient rehabilitation.
4. Outpatient rehabilitation therapy (physical therapy, speech therapy, occupational therapy, spinal manipulation services, and acupuncture).
5. Outpatient Therapeutic Treatment (ABA, respiratory therapy).
6. Outpatient procedures, including but not limited to musculoskeletal procedures, gastrointestinal procedures, cardiac procedures, and maxillofacial procedures.
7. Facility based office visits.
8. Habilitative Services for adults.
9. Electroconvulsive Therapy (ECT).
10. Repetitive Transcranial Magnetic Stimulation (rTMS).
11. Organ and Tissue Transplants.
12. Clinical trials and associated components of the trial.
13. Air Ambulance Services (Except for Medically Necessary air ambulance services in an emergency).
14. Skilled Nursing Facility.
15. Home Health Services.

16. Medical Devices and Supplies.
187. Imaging/Radiology.
18. Lab Testing.
19. Specialty medications and infusion services administered by a healthcare professional.
20. Gender Reassignment Services.
21. Infusion Services.
22. Radiation Therapy.
23. Genetic Testing.
24. Sleep Studies.
25. Infertility Treatment.
26. Out-of-Network Covered Services.

See https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page for a list of specific Covered Services which require prior authorization.

C. See Section 13.5F, Estimate of Eligible Benefits, for requirements for Pediatric Dental Services.

D. Prior authorization is not required for maternity admissions or any emergency services such as medical or Mental Health or Substance Use Disorder emergency admissions. Prior authorization is not required for any Covered Services when Medicare is the primary insurer.

E. CareFirst reserves the right to make changes to the categories of services that are subject to utilization management requirements or to the procedures the Member and/or the providers must follow. CareFirst will notify the Member of these changes at least forty-five (45) days in advance.

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]

[Name]
[Title]

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield
1440 G Street, NW
Washington, DC 20005
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

2027 AMENDMENT

This amendment is effective _____. If no date is shown, this amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

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SECTION A – OUTPATIENT FACILITY, OFFICE, AND PROFESSIONAL SERVICES
SECTION B – PEDIATRIC VISION SERVICES
SECTION C – PRESCRIPTION DRUGS
SECTION D – GENERAL PROVISIONS
SECTION E – DEFINITIONS

SECTION A – OUTPATIENT FACILITY, OFFICE, AND PROFESSIONAL SERVICES

1. Section 1.5B.5., Abortion Care, in the Description of Covered Services is deleted and replaced with the following:

   5. Abortion Care. Coverage will be provided for abortion care services. There is no Deductible, Copayment, or Coinsurance for abortion care. Except for Health Savings Account (HSA)-compatible plans to which the Member has contributed to his/her HSA during the Benefit Period, the Deductible, if any, does not apply to abortion care.

2. The first 2 paragraphs of Section 1.3, Preventive Services, in the Description of Covered Services are deleted and replaced with the following:

   1.3 Preventive Services
   In addition to the benefits listed in this provision, CareFirst will provide benefits for health exams and other services for the prevention and detection of disease, at intervals appropriate to the Member's age, sex, and health status, in accordance with the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended, as well as CareFirst preventive guidelines. At a minimum, benefits for preventive services listed in this provision will be provided once per Benefit Period.

   Benefits for preventive services will be provided for evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force (USPSTF). This includes benefits for preventive maternity care. Additionally, benefits will be provided for any other items or services which are consistent with the recommendations and guidelines set by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration, and related federal rules or guidance in effect on December 31, 2024, or at a later date that enhance the scope of preventive services.

SECTION B – PEDIATRIC VISION SERVICES

1. Section 3.1B.4.c)(1), Prior Authorization Required for Medically Necessary Prescription Contact Lenses, in the Description of Covered Services is deleted. Any subsequent sections are renumbered accordingly.

SECTION C – PRESCRIPTION DRUGS

1. In the Description of Covered Services, all references to *Prescription Guidelines* are deleted and replaced with *Formulary*.

2. Section 10.1J., Abortion Care, in the Description of Covered Services, is deleted and replaced with the following:

   J. Abortion Care. Coverage will be provided for abortion care Prescription Drugs. There is no Deductible, Copayment or Coinsurance for abortion care Prescription Drugs. Except for Health Savings Account (HSA)-compatible plans to which the Member has contributed to his/her HSA during the Benefit Period, the Deductible, if any, does not apply to abortion care Prescription Drugs.

3. Section 10.1, Covered Services, in the Description of Covered Services is amended to add the following:

   K. Abuse-Deterrent Opioid Analgesic Drug Products. CareFirst BlueChoice may apply quantity limits to opioid prescription drugs to help ensure safe and appropriate use as part of the utilization management strategy based on current clinical practice guidelines.

SECTION D – GENERAL PROVISIONS

1. Section 13.3, Limitation on Provider Coverage, in the Description of Covered Services is deleted and replaced with the following:

   13.3 Limitation on Provider Coverage
   Services are covered only if the provider is licensed or otherwise authorized under state law or the laws of the District of Columbia and if the services are within the lawful scope of the services for which that provider is licensed. Coverage does not include services rendered to the Member by any individual who:

   A. is the Member's Spouse, domestic partner, mother, father, daughter, son, brother, or sister; or

   B. resides in the Member's home.

SECTION E – DEFINITIONS

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

   Abuse-Deterrent Opioid Analgesic Drug Product means a brand name or generic opioid analgesic drug product approved by the U.S. Food and Drug Administration with abuse-deterrent labeling that indicates the drug product is expected to result in a meaningful reduction in abuse.

   Opioid Analgesic Drug Product means a drug product that contains an opioid agonist and is indicated by the U.S. Food and Drug Administration for the treatment of pain, regardless of whether the drug product:

A. is in immediate release or extended-release form; or

B. contains other drug substances.

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

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GROUP INCENTIVE PROGRAM RIDER

This rider is issued by CareFirst to be attached to and become part of the Evidence of Coverage. A Member's effective date of coverage under this rider and termination date of coverage under this rider are the same as the Member's effective date and termination date under the Evidence of Coverage.

This rider adds an incentive program to the Evidence of Coverage that rewards Members for: 1) selecting specific health care providers and completing a Health Screening 2) permitting the receipt of wellness-related communications and completing a Health Assessment; 3) updating/confirming the responses to the Health Assessment after a defined time period; 4) participating in health coaching sessions; 5) health challenges; 6) tobacco cessation; 7) emotional wellbeing; and/or 8) financial wellbeing.

Members receive incentives in the form of a credit to a debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card.

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SECTION A – DEFINITIONS
SECTION B – INCENTIVE ACTIVITIES AND REQUIREMENTS
SECTION C – INCENTIVE AMOUNTS
SECTION D – CONDITIONS AND LIMITATIONS

A. DEFINITIONS:

In addition to the definitions contained in the Evidence of Coverage to which this rider is attached, the underlined terms below, when capitalized, have the following meanings:

Annual Incentive means the amount of the reward provided to Eligible Members for satisfaction of the incentive requirements set forth in Section B of this rider.

Health Assessment means a questionnaire that asks about the Member's age, habits, recent test results, and medical history.

Health Screening means a diagnostic screening that captures biometrics to identify potential health risks.

B. INCENTIVE ACTIVITIES AND REQUIREMENTS:

Members who successfully complete the following requirements ("Eligible Members") will be provided an Annual Incentive as set forth in Section C, and in the form of a debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card, which can be used to pay any Copayments, Coinsurance, or Deductibles. Dependent Children are not eligible for any incentive amounts under this rider.

1. Select a PCP and Complete a Health Screening.

a) A Member must select a PCP within 180 days of enrollment or renewal.

b) A Member must complete a Health Screening and submit the results of the Health Screening to CareFirst within 180 days of enrollment or renewal.

2. Consent to Receive Wellness-Related Communications and Complete a Health Assessment.

a) A Member must provide consent to receive communications related to healthy lifestyles, well-being, wellness, and disease management information and activities within 180 days of enrollment or renewal.

b) A Member must complete the Health Assessment within 180 days of enrollment or renewal.

3. Update/Confirm the Health Assessment Responses.

a) To achieve this activity, a Member must complete the activities required in item B.2.

b) A Member must update their responses, which will be prepopulated with information provided during the Health Assessment activity completed in activity B.2.b.no earlier than 90 days after taking the original Health Assessment.

4. Participate in Health Coaching Sessions, Health Challenges, Tobacco Cessation, Emotional Wellbeing, and/or Financial Wellbeing.

a) Health Coaching Sessions. A Member must consent to participate in and complete coaching sessions. Coaching sessions provide voluntary and confidential one-on-one support with a primary coach to collaborate and help Members reach their health goals. Sessions are personalized to each Member and focused on developing health-related goals, helping Members understand their health risks and conditions, and preventing the progression of disease.

Members can earn rewards for completing one (1), two (2), or three (3) coaching sessions. Completing coaching sessions are based on Member participation and not dependent on achieving an outcome and/or health-related goals. Only one (1) coaching session per 30 days will count towards an incentive. A maximum of three (3) coaching sessions per Benefit Period will count towards the incentive.

b) Health Challenges through CareFirst Wellbeing. Participate in up to eight (8) challenges within the Benefit Period. Every two challenges for a maximum of eight (8) challenges will earn the reward for the Benefit Period. Challenges are tracked within the CareFirst Wellbeing platform or app, available to all Members, where the Member elects to join and each day inputs their activity of the specific challenge such as daily steps, stress management, healthy eating, or sleep tracking. A variety of challenge topics are offered each month. Within the platform, a Member will see progress towards completion, along with the number of days left to complete the challenge(s). Once a Member completes the challenge(s), the completion status will show in the platform, and the Member will earn the reward.

c) Tobacco Cessation digital program through CareFirst Wellbeing. The tobacco cessation is accessed through the platform or app available to all CareFirst Members. A Member must complete all twenty-two (22) modules of the Craving To Quit tobacco cessation program within the Benefit Period to earn the reward.

d) Emotional Wellbeing program through CareFirst Wellbeing Program. The platform or app is available to all CareFirst Members. A Member must engage ten (10) times in one (1) month for activities within Unwinding: breathing exercise, take five, any guided meditation, meditation time, visual relaxation video, mindful moment, or a mindful check-in. Members can earn rewards for engagement ten (10) times per month for up to four (4) months in the Benefit Period. A Member can track the activities completed and their progress within the platform/app. Once a Member completed the exercises, they will receive a status update. Once a Member completes the 10 activities, the Member will receive a completion check mark and corresponding reward.

e) Financial Wellbeing through CareFirst Wellbeing. The program or app is available to all CareFirst Members. Members may enroll in Smart Dollar by selecting the enroll button, setting their personal goals, and begin the course which includes budgeting, savings, and/or getting out of debt, and engage in actions to earn 1,000 Smart Dollar points in the Benefit Period. The 1,000 Smart Dollar points are earned by the Member by logging into the program 20 times in a Benefit Period and completing activities of their choice. These activities may include attending a digital lesson; reading content and taking a quiz; creating a budget; developing a plan to pay off debt; updating tracker balance; completing a financial wellbeing survey; and/or updating the Baby Step tracker. The 1,000 Smart Dollar points are equal to $100 dollars. Once a Member completes 20 activities within the Benefit Period, a check mark will appear within the platform/app showing completion of the steps and the reward is earned.

C. INCENTIVE AMOUNTS

1. **Select a PCP and Complete a Health Screening.** Members who complete the participation requirements in Section B.1 will receive the Annual Incentive in the form of a debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card equal to $100 per Benefit Period.

   Eligible Members will be issued the Annual Incentive on an individual basis as the incentive is earned.

2. **Consent to Receive Wellness-Related Communications and Complete a Health Assessment.** Members who complete the participation requirements in Section B.2 will receive the Annual Incentive in the form of a debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card equal to $200 per Benefit Period.

   Eligible Members will be issued the Annual Incentive on an individual basis as the incentive is earned.

3. **Update/Confirm the Health Assessment Responses.** Members who complete the participation requirements in Section B.3 will receive the Annual Incentive in the form of a debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card equal to $25 per Benefit Period.

   Eligible Members will be issued the Annual Incentive on an individual basis as the incentive is earned.

4. **Participate in Health Coaching Sessions.** Members who complete the participation requirements in Section B.4 will receive the annual incentive in the form of a debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card equal to $30 for coaching session one (1), $70 for coaching session two (2), $100 for coaching session three (3).

A maximum incentive of $200 per Benefit Period, per Member, can be earned under this provision.

Eligible Members will be issued the Annual Incentive on an individual basis as the incentive is earned.

5. **Health Challenges through CareFirst Wellbeing**. Members who enroll and complete the requirements in Section B.4.b) will receive the annual incentive in the form of a debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card equal to $25 for participation in two (2) challenges with each additional participation in two (2) challenges to earn $25 for a maximum of 8 challenges.

   Participation in up to eight (8) challenges per Benefit Period earning a maximum incentive of $100 per Benefit Period per Member, can be earned under this provision.

6. **Tobacco Cessation digital program through CareFirst Wellbeing:** Members who enroll and complete the requirements of Section B.4.c) will receive the annual incentive in the form of a debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card equal to $200.

   Eligible Members will be issued the Annual Incentive on an individual basis as the incentive is earned.

7. **Emotional Wellbeing program through CareFirst Wellbeing.** Members who enroll and complete the requirements of Section B.4.d) will receive the annual incentive in the form of a debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card equal to $100.

   Eligible Members will be issued the Annual Incentive on an individual basis as the incentive is earned.

8. **Financial Wellbeing through CareFirst Wellbeing.** Members who enroll and complete the requirements of Section B.4.e) will receive the annual incentive in the form of a debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card equal to $100.

   Eligible Members will be issued the Annual Incentive on an individual basis as the incentive is earned.

9. **Maximum Annual Incentive**. The total Maximum Annual Incentive may not exceed $375 per Eligible Member for completion of all participation incentives.

D. CONDITIONS AND LIMITATIONS

1. Members are eligible to qualify for each incentive once per Benefit Period.

2. Only one debit card, gift card, or medical expense debit card will be issued to the Subscriber. Funds will be applied to the Subscriber's card based on rewards or incentive earned by the Subscriber and/or the Subscriber's eligible Dependents. The debit card, gift card, or medical expense debit card may be used by the Subscriber and/or the Subscriber's eligible Dependents.

3. Members may satisfy the Health Screening requirement in Section B.1 through the Member's PCP, other In-Network provider or any process approved by CareFirst.

4. Once the Annual Incentive is awarded in a Benefit Period, it will not be withdrawn nor any amounts recouped during the Benefit Period.

5. Members agree to comply with any requirements concerning the use of the debit card, gift card, Health Savings Account (HSA) funding, or medical expense debit card

6. If the Member's Evidence of Coverage is compatible with a federally qualified Health Savings Account, the medical expense debit card:

   a) the Member will need to acknowledge, prior to earning a reward, that they understand that the debit card cannot be used to pay for qualified medical expenses or other cost-sharing responsibilities unless (i) the Member first satisfies his/her plan deductible as established by the Internal Revenue Service or (ii) the Member and their employer are not funding the Health Savings Account (HSA) and agree not to fund the HSA account during the Benefit Period; and

   b) can be used to pay for eligible dental and vision expenses that are part of the Member's benefit plan.

7. If the coverage allows for out-of-area benefits that extend beyond Emergency Services, Urgent Care, and follow-up care after emergency surgery, Members residing outside of CareFirst's service area will earn the participation incentive by selecting a participating provider in a PCP-like specialty (family practice, general practice, internist, geriatrics, pediatrics) in the Blue Cross and Blue Shield Plan where the Member resides and completing the activities identified in Section B.1.

8. Only a Subscriber and Subscriber's Dependent Spouse, or, if applicable, the Subscriber's Dependent Domestic Partner, are eligible for incentives under this rider. Dependent Children are not eligible for any incentives under this rider.

9. A Member may not be able to meet a standard related to a health factor because it is unreasonably difficult for him or her to satisfy, or inadvisable to attempt to satisfy, due to a medical condition. In this instance, the Member may call us at the telephone number listed on their ID card. We will work with the Member (and, if necessary, with the Member's Physician) to come up with an alternative standard to earn the same reward.

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

Group Hospitalization and Medical Services, Inc.

[Signature]

[Name]
[Title]

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840 First Street, NE
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PATIENT PROTECTION DISCLOSURE NOTICE

Primary Care Provider Designation

CareFirst generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, CareFirst designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the CareFirst at the customer service telephone number listed on your identification card.

For children, you may designate a CareFirst pediatrician as the primary care provider.

Obstetrics and Gynecological Care

You do not need prior authorization from CareFirst or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of CareFirst health care professionals who specialize in obstetrics or gynecology, contact CareFirst at customer service telephone number listed on your identification card.

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SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers or health maintenance organizations who sell health benefit plans, disability income insurance, long-term care insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons who reside in the District of Columbia. However, the protection provided through the Guaranty Association is subject to certain statutory limits explained under the "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep them in-force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code §31-5401 et seq.), provides insolvency protection for certain types of insurance policies and contracts. The insolvency protections provided by the Guaranty Association are generally conditioned on an a person being 1) a resident of the District of Columbia and 2) either the individual insured or an owner under a health benefit plan, disability income insurance, long-term care insurance, life insurance, or annuity contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also generally covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
  - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term insurance care benefits;
  - $300,000 for disability income insurance benefits;
  - $500,000 for health benefit plans;
  - $100,000 for coverage not defined as disability income insurance; health benefit plans; or long-term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 in benefits with respect to any one life (except in the event of health benefit plans in which the Guaranty Association is liable for no more than $500,000).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner, regardless of the number of policies owned.

Exclusions Examples
Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia at the time the policy or contract was issued; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits, or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Consumer Protection

To learn more about the above referenced protections, please visit either:

District of Columbia
Life and Health Insurance
Guaranty Association
www.dclifega.org
410-248-0407

District of Columbia
Department of Insurance, Securities
and Banking
disb.dc.gov
202-727-8000

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association will cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.

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ATTACHMENT D
ELIGIBILITY SCHEDULE

Effective Date	Effective as of the Group Contract Effective Date.
ELIGIBILITY	
Subscriber	A Qualified Employee, who works at least 30 hours per week on a regular (not seasonal or temporary) basis, is eligible to enroll.
Spouse	Coverage for a Spouse is available.
[Domestic Partner	Coverage for Domestic Partner is available.]
Dependent Children	Coverage for Dependent Children is available.
Limiting Age for Dependent Children (other than an incapacitated Dependent Child)	Age 26
ENROLLMENT PERIODS AND EFFECTIVE DATES	
Annual Open Enrollment and Newly Eligible Qualified Employees	
Annual Open Enrollment	Coverage is effective on the Group Contract Effective Date.
Newly Eligible Qualified Employee	A newly eligible Qualified Employee is eligible to enroll him or herself and any eligible Dependents on the date of the Qualified Employee's employment in the Group. The enrollment period for a new Qualified Employee and any Dependents is thirty (30) days from the date of the Qualified Employee's employment in the Group. The Effective Date of coverage is: A. For enrollment received by the SHOP Exchange between the first and the fifteenth day of the month, the first day of the following month; and B. For enrollment received by the SHOP Exchange between the sixteenth and the last day of the month, the first day of the second following month.

Special Enrollment Periods	
Newly Eligible Dependent Child: (Newborn Dependent Child, Newly Adopted Dependent Child, a Minor Dependent Child for whom guardianship has been granted by court or testamentary appointment, or MCSO/QMSO)	The Special Enrollment Period is the thirty-one (31) day period from the date of the qualifying event. The Effective Date of coverage is the Dependent Child's First Eligibility Date: A. Newly born Dependent Child: the date of birth. B. Adopted Dependent Child: the date of Adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent. C. Testamentary or court appointed guardianship of a Dependent Child: the date of appointment. D. 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. If the Qualified Employee is enrolled, the newly eligible Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the child's First Eligibility Date. The Subscriber must enroll such a Dependent Child within thirty-one (31) days of the child's First Eligibility Date.
Newly Eligible Dependent (including a Spouse or a newly eligible Dependent Child not described above)	The Special Enrollment Period is the thirty-one (31) day period from the date of the qualifying event. The Effective Date of coverage is the first day of the month following the receipt of enrollment by the SHOP Exchange.
Eligible Qualified Individual who loses other Minimum Essential Coverage (as provided in the Evidence of Coverage)	The Special Enrollment Period is the thirty (30) day period from the date of the qualifying event. The Effective Date of coverage is the first day of the month following the receipt of enrollment by the SHOP Exchange.
Eligible Qualified Individual who loses coverage under a Medicaid plan or a state child health plan,(as provided in the Evidence of Coverage)	The Special Enrollment Period is the sixty (60) day period from the date of the qualifying event. The Effective Date of coverage is the first day of the month following the receipt of enrollment by the SHOP Exchange.
Eligible Qualified Individual or is permitted to terminate coverage under a non-qualifying employer-sponsored health benefit plan (as provided in the Evidence of Coverage)	The Special Enrollment Period shall be sixty (60) days prior to the end of coverage under the employer sponsored plan. The Effective Date of coverage is the first day of the month following the receipt of enrollment by the SHOP Exchange.

Eligible Qualified Individual who becomes eligible to enroll due to any other qualifying event stated in Section 2.5 of the Evidence of Coverage	The Special Enrollment Period is the thirty (30) day period from the date of the qualifying event. The Effective Date of the Qualified Individual's coverage will be: A. For enrollment received by the SHOP Exchange between the first and the fifteenth day of the month, the first day of the following month; and B. For enrollment received by the SHOP Exchange between the sixteenth and the last day of the month, the first day of the second following month. For a Qualified Individual who enrolls during a Special Enrollment Period due to (i) an error by the SHOP Exchange or the United States Department of Health and Human Services; (ii) another Qualified Health Plan substantially violating a material provision of its contract with the Qualified Individual; or (iii) other exceptional circumstances as determined by the SHOP Exchange, the Effective Date of the Qualified Individual's coverage will be established by the SHOP Exchange to be either: A. The date of the event that triggered the Special Enrollment Period under these circumstances; or B. The Effective Date set forth for all other circumstances stated above.
TERMINATION OF ENROLLMENT	
Termination of Enrollment by the Subscriber	
Subscriber terminates enrollment of a Member	Termination is effective: A. If notice of termination of enrollment given because a Member will enroll in another Qualified Health Plan: the day before the effective date of coverage under the new Qualified Health Plan. B. If notice of termination of enrollment given because a Member is newly eligible for Medicaid, the federal child health insurance plan (CHIP) or a State-funded low-income basic health plan (known as a BHP): the day before coverage under one of these programs begins. C. In all other cases: 1. On the date stated by the Subscriber, if the Subscriber has given reasonable notice. For purposes of this provision, reasonable notice is defined as fourteen (14) days from the requested termination date; or 2. Fourteen (14) days after the date the Subscriber requested termination, if the Subscriber does not provide reasonable notice.
Termination of Enrollment by CareFirst or the SHOP Exchange	
Subscriber no longer eligible as a Qualified Employee	When the Subscriber is no longer eligible as a Qualified Employee, enrollment of the Subscriber and any Dependents terminates on the last day of the month that the Subscriber and/or Dependent no longer meet the eligibility requirements stated in the Evidence of Coverage or as instructed by the SHOP Exchange. Extension of benefits and continuation of coverage rights are stated in the Evidence of Coverage.

Dependent Child Limiting Age (other than a Dependent Child who is incapacitated as provided in the Evidence of Coverage)	When a Dependent Child reaches the Limiting Age (other than a Dependent Child who is incapacitated as provided in the Evidence of Coverage), enrollment terminates on December 31 of the Calendar Year in which the Dependent Child reached the Limiting Age, unless otherwise instructed by the SHOP Exchange. Extension of benefits rights are stated in the Evidence of Coverage.
Dependent no longer eligible (on grounds other than Limiting Age)	When a Member no longer meets the eligibility requirements stated in the Evidence of Coverage, (on grounds other than reaching the Limiting Age), enrollment terminates on the last day of the month in which the Member no longer meets the eligibility requirements, or as instructed by the SHOP Exchange. Extension of benefits and continuation of coverage rights, if any, are stated in the Evidence of Coverage.
Death of Subscriber	Upon the death of the Subscriber, enrollment of the Subscriber terminates on the date of death or as instructed by the SHOP Exchange. The enrollment of any Dependents terminates on the last day of the month after the Subscriber's death. Extension of benefits and continuation of coverage rights are stated in the Evidence of Coverage.