CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

BLUECHOICE PROGRAM DESCRIPTION

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

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

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

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

SECTION 1
DEFINITIONS

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

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

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

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

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

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

CareFirst means CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield.

Claims Administrator means CareFirst.

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

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

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

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

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

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

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

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

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

B. The Technology must improve the net health outcome;

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

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

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

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

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

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

A. Licensed by the appropriate State authorities; or

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

C. Approved by Medicare.

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

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

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

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

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

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

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

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

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

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

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

Membership Categories under the Contract are:

- **Individual Coverage**, which covers the Eligible Employee only;
- **Individual and Adult** , which covers the Eligible Employee and:
  - Spouse
- **Individual and Child**, which covers the Eligible Employee and:
  - Dependent Child
- **Individual and Children**, which covers the Eligible Employee and:
  - Dependent Children
- **Family Coverage**, which covers the Eligible Employee and two or more Dependents.

Additionally, **Retired** Eligible Employee may elect one of the following:

- **Medicare Complementary** (entitled to Medicare Parts A & B): Coverage for Eligible Employee only
- **Individual + 1 Medicare** (One person has Medicare coverage) Coverage for the Eligible Employee and**:**
  - Spouse, and or eligible Dependent Children; or
  - Eligible Dependent Child
- **Two Medicare Complementary** (both persons have Medicare coverage) Coverage for Eligible Employee and;
  - Spouse,
  - Eligible Dependent Child

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

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

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

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

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

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

Service Area means the geographic area within which CareFirst BlueChoice's services are available. The Service Area is as follows: the District of Columbia; the State of Maryland; in the state of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince Williams Counties in Virginia lying east of Route 123. CareFirst may amend the defined Service Area at any time, with notification to the Group.

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

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

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

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

SECTION 2
ELIGIBILITY AND ENROLLMENT

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

A. The individual must be eligible for coverage either as an Eligible Employee pursuant to Section 2.2, below or, if applicable, as a Spouse, or Dependent pursuant to Section 2.3, or 2.4 below;

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

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

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

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

A. Basic Requirements. An Eligible Employee must reside or work in the Service Area.

B. Additional Eligibility Requirements.

The following individuals are eligible to enroll as Eligible Employees:

1. **A full-time wage-earning employee**; who works at least 25; other hours per week on a regular (not seasonal or temporary) basis**;**

2. **Faculty Leave** the Group's benefits program includes provisions for faculty members' research and sabbatical leaves. Faculty members who are on research or sabbatical leave are considered to be on full-time, active status while on leave. Therefore, the Eligible Employee's coverage will continue during his or her leave, as long as he or she continues to make the required contributions towards the cost of his or her benefits;

3. An eligible employee or eligible participant of the Group, who is subject to (a) the provisions of the Federal Family and Medical Leave Act of 1993, as amended; and/or (b) the provisions of an equivalent or comparable statute or regulation of the appropriate State or jurisdiction, as stated therein;

Every Retiree within the classification of Eligible Retirees set forth below shall be eligible for coverage for himself and his Dependents. The following individuals are eligible to enroll as Retiree/Members:

1. **Retirees** who retire on or after the Effective Date of the Contract and who are eligible in accordance with the provisions of the Group's retirement plan; and

2. **Retirees** who have retired prior to the Effective Date of the Contract provided the individual was covered as a Retiree under the Group's prior program and who are eligible in accordance with the provisions of the Group's retirement plan.

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

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

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

2.4 Eligibility of Dependent Children. The Group may elect to provide coverage for eligible Dependent Children. A Dependent Child means an individual who:

A. Is:

1. A natural child;

2. A legally adopted child or grandchild;

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

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

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

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

B. Is under the Limiting Age stated in Section 2.5 below; 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 medical or mental disability; (2) that the Dependent Child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse for support and maintenance; and (3) that the Dependent Child had been covered under the Subscriber's or the Subscriber's Spouse's prior health insurance coverage since before the onset of the medical or mental disability.

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

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

A. All Dependent Children are eligible up to age 26;

B. A Dependent Child will be eligible for coverage past the Limiting Age of **26** if:

1. The child is unmarried and is incapable of supporting him or herself because of medical or mental disability;

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

3. The child is primarily dependent upon the Eligible Employee or the Eligible Employee's Spouse for support and maintenance; and

4. The Member provides CareFirst with proof of the child's certified medical or mental disability within 31 days after the child reaches the Limiting Age for Dependent children, or if applicable, the Limiting Age for Student Dependents. CareFirst has the right to verify whether the child is and continues to qualify as a disabled Dependent child.

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

A. **Annual Open Enrollment.** The Group will have an annual open enrollment period of between 15 and 31 days duration. Each open enrollment period will, unless otherwise agreed to in advance by CareFirst, be held annually within 60 days preceding the open enrollment Effective Date/Anniversary Date. During the open enrollment period, the Group will provide an opportunity to all Eligible Employees to enroll in or transfer coverage between CareFirst and all other alternate health care plans available through the Group. In addition, Eligible Employees already enrolled in CareFirst may change their Membership Category (e.g., from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage.

B. **Newly Eligible Employee.** Newly Eligible Employees may enroll within 31 days after they first become eligible as determined within Section 2, Eligibility and Enrollment. If such individuals do not enroll within this period and do not qualify for the Special Enrollment Period as described in Section 2.6.E, Special Enrollment Periods, they must wait for the Group's next open enrollment period.

C. **Coverage of a Newborn, Newly Adopted Child, Newly Eligible Grandchild or a Minor to whom Guardianship is granted by Court or Testamentary Appointment.** Eligible Employees may enroll new family members, such as an eligible newborn child, newly adopted child, newly eligible grandchild or a minor for whom guardianship is granted by court or testamentary appointment and/or change their Membership Category to include the new family member within 31 days following the date the new family member first becomes eligible. If this election is not made within this period and the new family member does not qualify for the Special Enrollment Period as described in Section 2.6.E, the new family member(s) may not enroll until the Group's next open enrollment period. The date of the child's First Eligibility Date is defined below:

First Eligibility Date:

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

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

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

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

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

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

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

D. **New Family Member (Other than a newborn or newly adopted child or newly eligible grandchild or a minor to whom guardianship is granted by court or testamentary appointment).** The Eligible Employee may enroll new family members, such as a new Spouse, or stepchild, and/or change the Membership Category to include the new family member within 31 days following the date the new family member first becomes eligible. If this election is not made within this period and the new family member does not qualify for the Special Enrollment Period as described in Section 2.6.E, the new family member(s) may not enroll until the Group's next open enrollment period.

First Eligibility Date:

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

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

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

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

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

1. Special enrollment for certain individuals who lose coverage:

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

   b Individuals eligible for special enrollment.

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

         i) The Eligible Employee and the dependents are otherwise eligible to enroll;

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

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

2) When dependent loses coverage.

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

A) The dependent and the Eligible Employee are otherwise eligible to enroll;
B) When coverage was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and
C) The dependent satisfies the conditions of paragraph 1.c.1), 2), or 3) of this section, and if applicable, paragraph 1.c.4) of this section.

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

3) Conditions for special enrollment.

i) Loss of eligibility for coverage. In the case of an Eligible Employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph a)3)i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph does not include a loss due to the failure of the Eligible Employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:

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

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

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

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

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

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

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

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

2. Special enrollment with respect to certain dependent beneficiaries:

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

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

      1) Current Eligible Employee only. A current Eligible Employee is described in this paragraph if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

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

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

         ii) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

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

         i) The Eligible Employee and the spouse become married; or

         ii) The Eligible Employee and spouse are married and a child becomes a dependent of the Eligible Employee through birth, adoption, or placement for adoption.

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

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

      6) Current Eligible Employee, spouse, and a new dependent. A current Eligible Employee, the Eligible Employee's spouse, and the Eligible Employee's dependent are described in this paragraph if the dependent becomes a dependent of the Eligible Employee through marriage, birth, adoption, or placement for adoption.

First Eligibility Date:

a. Special enrollment for certain individuals who lose coverage

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

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

b. Special enrollment for certain Dependent beneficiaries

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

Dependents are effective as follows:

In the case of marriage: the date of marriage.

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

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

F. **Special Enrollment Regarding Medicaid and CHIP Termination or Eligibility.**

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

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

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

2. Notification Requirement.

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

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

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

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

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

G. **Special Enrollment for Individuals Terminated Prior to September 23, 2010 for Reaching the Limiting Age or Reaching the Lifetime Limit**

1. Special enrollment transition for an adult child previously denied enrollment or who terminated coverage due to attaining Limiting Age in accordance with the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act, *PHS Act Section 2714, Eligibility of Children Until Age 26 (26 CFR 54.9815–2714, 29 CFR 2590.715–2714, 45 CFR 147.120),* ("section").

a. In general. The relief provided in the transitional rules of this paragraph d. applies with respect to any child—

1) Whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26 (which, under this section, is no longer permissible); and

2) Who becomes eligible (or is required to become eligible) for coverage under a group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010 by reason of the application of this paragraph.

b. Opportunity to enroll.

1) If a group health plan, or group health insurance coverage, in which a child described in paragraph G.1 of this section is eligible to enroll (or is required to become eligible to enroll) is the plan or coverage in which the child's coverage ended (or did not begin) for the reasons described in paragraph G.1a of this section, and if the plan, or the issuer of such coverage, is subject to the requirements of this section, the plan and the issuer are required to give the child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). This opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010.

2) The written notice must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan or coverage. The notice may be provided to an Eligible Employee on behalf of the Eligible Employee's child. In addition, the notice may be included with other enrollment materials that a plan distributes to Eligible Employees, provided the statement is prominent. If a notice satisfying the requirements of this paragraph b.2) is provided to an Eligible Employee whose child is entitled to an enrollment opportunity under this paragraph b., the obligation to provide the notice of enrollment opportunity under this paragraph b.2) with respect to that child is satisfied for both the plan and the issuer.

c. Effective date of coverage. In the case of an individual who enrolls under paragraph G.1.b of this section, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

d. Treatment of enrollees in a group health plan. Any child enrolling in a group health plan pursuant to paragraph b.2) of this section must be treated as if the child were a special enrollee, as provided under the rules of § 54.9801–6(d). Accordingly, the child (and, if the child would not be a participant once enrolled in the plan, the participant through whom the child is otherwise eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

2. Special enrollment transition for individuals whose coverage or benefits ended by reason of reaching a lifetime limit in accordance with the Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule.

   a. In general. The relief provided in the transitional rules of this paragraph 2 applies with respect to any individual—

      1) Whose coverage or benefits under a group health plan or group health insurance coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits for any individual (which, under this section, is no longer permissible); and

      2) Who becomes eligible (or is required to become eligible) for benefits not subject to a lifetime limit on the dollar value of all benefits under the group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010, by reason of the application of this section.

   b. Notice and enrollment opportunity requirements—

      1) If an individual described in paragraph G.2.a of this section is eligible for benefits (or is required to become eligible for benefits) under the group health plan--or group health insurance coverage--described in paragraph G.2.a.1) of this section, the plan and the issuer are required to give the individual written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan and issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity required under this paragraph b.1) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010.

      2) The notices required under paragraph G.2.b of this section may be provided to an Eligible Employee on behalf of the Eligible Employee's dependent. In addition, the notices may be included with other enrollment materials that a plan distributes to Eligible Employees, provided the statement is prominent. For either notice, if a notice satisfying the requirements of this paragraph G.2.b is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer.

c. Effective date of coverage. In the case of an individual who enrolls under paragraph G.2.b of this section, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

d. Treatment of enrollees in a group health plan. Any individual enrolling in a group health plan pursuant to paragraph G.2.b of this section must be treated as if the individual were a special enrollee, as provided under the rules of Sec. 2590.701-6(d) of this part. Accordingly, the individual (and, if the individual would not be a participant once enrolled in the plan, the participant through whom the individual is otherwise eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package. The individual also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

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

A. **Open Enrollment Effective Date**. Enrollment or changes in enrollment will be effective May 19, 2011, which is the Group's Open Enrollment Effective Date/Anniversary Date, if the requirements of Section 2.6.A are met.

B. **New Employee/Members.** Coverage of new Eligible Employees will be made effective on the date defined by the Group, if the requirements of Section 2.6.B are met.

If a Section 125 Plan, within 31 days after any event which, in the judgment of the Plan Administrator qualifies as a status change or other allowable change under Section 125 of the Internal Revenue Code (family status changes) a new Eligible Employee is eligible for coverage effective the first of the month following acceptance of the enrollment form by CareFirst.

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

D. **Coverage of Other Newly Eligible Dependents**. Coverage of other newly eligible Dependents; e.g., a new Spouse, or stepchild, will be made effective in accordance with the Eligibility Date stated in Section 2.6., provided the newly eligible Dependent is enrolled within 31 days following the date upon which the Dependent first became eligible.

If a Section 125 Plan, within 31 days after any event which, in the judgment of the Plan Administrator qualifies as a status change or other allowable change under Section 125 of the Internal Revenue Code (family status changes) Dependents of a new Subscriber are eligible for coverage effective the first of the month following acceptance of the enrollment form by CareFirst.

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

SECTION 3
MEDICAL CHILD SUPPORT ORDERS

3.1 Definitions

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

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

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

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

3.2 Eligibility and Termination

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

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

First Eligibility Date:

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

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

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

1. Was born out of wedlock.

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

3. Does not reside with the Subscriber.

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

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

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

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

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

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

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

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

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

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

C. Provide benefits directly to:

1. The non-insuring parent;

2. The provider of the covered services; or

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

SECTION 4
TERMINATION OF COVERAGE

4.1 Disenrollment of Individual Members

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

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

Coverage of individual Members will terminate for the following reasons.

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

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

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

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

E. The Group is required to notify the Subscriber if a Member's coverage is cancelled. If the Group does not notify the Subscriber, this will not continue the Member's coverage beyond the termination date of coverage. The Member's coverage will terminate on the termination date stated in 4.2 below.

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

4.2 Termination of Coverage by the Eligible Employee.

A. Except as otherwise provided all Eligible Employee benefits under the Contract will end as stated below.

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

   a. Coverage for all Members under this Contract will terminate at the end of the month the Subscriber's eligibility ceases as stated in Section 2, Eligibility and Enrollment.

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

   a. Coverage under this Contract will terminate at the end of the month when eligibility ceases as stated in Section 2, Eligibility and Enrollment, except as follows and as stated in Section 3, Medical Child Support Orders.

   b. Coverage for a Dependent Child will terminate at the end of the month in which the Dependent Child no longer meets the qualifications for a Dependent Child.

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

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

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

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

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

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

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

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

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

A. The date the confinement ceases;

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

C. 90 days following termination.

SECTION 5
MULTIPLE COVERAGE

5.1 Coordination of Benefits ("COB")

A. **Applicability**

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

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

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

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

B. **Definitions**

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

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

CareFirst Plan means this Contract.

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

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

The term Plan does not include:

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

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

3. Coverage regulated by a motor vehicle reparation law;

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

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

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

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

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

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

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

C. **Order of Determination Rules**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2) Second, the benefits under the continuation coverage.

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

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

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

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

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

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

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

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

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

2. Insurance companies, or,

3. Other organizations.

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

5.2 Employer or Governmental Benefits

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

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

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

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

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

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

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

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

Coverage Secondary to Medicare

Except where prohibited by law, CareFirst benefits are secondary to Medicare.

Medicare as Primary

1. When benefits for Covered Services are paid by Medicare as primary, CareFirst will not duplicate those payments. When CareFirst coordinates the benefits with Medicare:

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

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

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

For a Member who elects Medicare Part B, continued

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

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

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

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

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

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

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

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

5.4 Personal Injury Protection ("PIP") Coverage.

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

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

5.5 Subrogation

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

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

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

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

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

SECTION 6
CLAIMS PROCEDURES

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

A. SCOPE AND PURPOSE

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

B. CLAIMS PROCEDURES

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

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

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

C. CLAIMS PROCEDURES COMPLIANCE

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

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

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

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

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

D. CLAIM FOR BENEFITS

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

E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

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

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

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

      1) Receipt of the specified information, or

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

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

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

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

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

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

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

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

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

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

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

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

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

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

   e. In the case of an Adverse Benefit Determination:

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

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

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

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

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

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

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

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

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

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

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

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

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

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

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

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

1. In general. Except as provided in item H.2., a Claimant shall be Notified in accordance with item I. herein of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or the Plan's Designee expects to render the determination on review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

J. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

   a. Was relied upon in making the benefit determination;

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

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

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

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

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

SECTION 7
GENERAL PROVISIONS

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

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

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

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

A. Medical Claims (for the BlueChoice Program Option) – must be submitted by the end of the year following the year during which the services were rendered.

D. Vision Claims (Routine) – twelve (12) months after the date the services were rendered or supplies were received.

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

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

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

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

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

7.7 Member Statements. Except in the instance of fraud, all statements made by Members shall be considered representations and not warranties and no such statement shall be the basis for avoiding coverage or denying a claim after coverage has been in force for two years from its Effective Date, unless the statement was material to the risk and was contained in a written application. Any rescission of coverage of any Member shall only be based upon an act, practice or omission that constitutes fraud or is due to an intentional misrepresentation. CareFirst shall give 30-days advance written notice of any rescission of coverage of any Member.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.18 Events outside of CareFirst's Control.

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

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

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

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

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

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

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

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

SECTION 8
INTER-PLAN ARRANGEMENTS DISCLOSURE

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

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

A Member will be entitled to benefits for Covered Services accessed either inside or outside the geographic area CareFirst serves. Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst's service area, e.g., Emergency Services.

For purposes of BlueChoice, "Out-of-Area Covered Emergency Services" means:

1. Emergency Services;

2. Urgent Care;

3. Follow-up care after emergency surgery for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's primary care provider ("PCP").

Member liability for Out-of-Area Covered Emergency Services is limited to the Member Payment for Emergency Services and Urgent Care as set forth in the Program Description. All other healthcare services rendered outside the geographic area CareFirst serves are not covered.

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

A. Definitions

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

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

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

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

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

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

B. BlueCard® Program

Under the BlueCard® Program, when Members access Covered Services from a PPO Provider or Participating Provider within the geographic area served by a Host Blue, CareFirst will remain responsible to Group for fulfilling CareFirst contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its PPO/Participating Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

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

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

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

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

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

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

C. Non-Participating Providers Outside the CareFirst Service Area

Member Liability Calculation

1. In General

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

2. Exceptions

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

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

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

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

Out-of-Area Services	Benefit Level
Out-of-Area Covered Emergency Services	**All Inter-Plan Programs: In-Network**
	Member liability for Out-of-Area Covered Emergency Services is limited to the Member Payment for Emergency Services and Urgent Care as set forth in the Program Description
All other Covered Services	**BlueCard® Program: Out-of-Network**
	When rendered by a BlueCard Traditional network or BlueCard PPO network provider: Member liable up to the Allowed Benefit
	Non-Participating Healthcare Providers: Out-of-Network
	Member liable up to charge (balance billing permitted)

ATTACHMENT A
DESCRIPTION OF COVERED SERVICES
BLUECHOICE PROGRAM OPTION

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

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SECTION 1
GENERAL PROVISIONS

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

Allowed Benefit means:

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

2. a. Non-contracted health care practitioner: For a health care practitioner that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is determined in the same manner as the Allowed Benefit for a Health Care Provider that has contracted with CareFirst. The benefit is payable to the Subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the health care practitioner. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.

   b. Non-contracted hospital or health care facility: For a hospital or health care facility that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or the established fee schedule if one has been established for that type of eligible provider and service. If a fee schedule for the type of eligible provider and service has not been established, the Allowed Benefit will be based on facility reimbursement methodology. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Member payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Subscriber or to the hospital or health care facility, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the hospital or health care facility. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.

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

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

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

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

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

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

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

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

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

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

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

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

1.2 Selection of a Primary Care Physician.

A. A Member must select a Primary Care Physician and may select any Primary Care Physician from CareFirst BlueChoice's current list of Contracting Physicians. If the Primary Care Physician is not available, the CareFirst BlueChoice will assist the Member in making another selection.

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

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

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

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

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

2. If there is no room on their panel and/or will not accept the Member as a patient, there is no coverage.

Except for that noted in Section, 11.4, Conditions for a Referral to a Non-Contracting Specialist or Non-Contracting Nonphysician Specialist, if a Member receives services from:

1. A Contracting Provider that is not a Primary Care Physician, (without a referral) there is no coverage;

2. Any Non-Contracting Provider, there is no coverage.

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

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

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

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

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

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

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

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

SECTION 2
OUTPATIENT AND OFFICE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In Contracting Physicians' offices or in other Contracting Provider facilities when provided by or upon written referral from a PCP. Coverage for the services listed below.	The coverage is subject to the limitations, if any, stated in this Attachment or in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

MOST CARE MUST BE PROVIDED BY, OR UPON WRITTEN REFERRAL OF THE MEMBER'S PCP.

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

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

B. Diagnostic Procedures.

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

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

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

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

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

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

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

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

3. Breast cancer screening benefits provided accordance with the latest screening guidelines issued by the American Cancer Society.

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

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

1. Employment;

2. Insurance;

3. Travel;

4. School;

5. Camp admissions; or

6. Participation in sports activities.

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

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

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

A Member who is pregnant may self refer to a Contracting Provider obstetrician-gynecologist. Thereafter, the obstetrician-gynecologist may assume responsibility for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with CareFirst BlueChoice's policies and procedures, through the postpartum period.

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

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

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

J. Eye Examinations. Eye examinations for the diagnosis and treatment of a medical condition.

K. Routine Hearing Screenings.

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

1. Definitions.

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

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

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

2. Covered Physical Therapy, Speech Therapy, or Occupational Therapy services are not subject to referral or utilization management requirements.

M. Radiation Therapy.

N. Chemotherapy.

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

1. Contraceptive counseling;

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

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

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

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

Q. Blood and Blood Products.

1. Administration of infusions and transfusions.

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

R. Spinal Manipulation Services.

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

2. Covered spinal manipulation services are not subject to referral or utilization management requirements.

S. Limited Service Immediate Care. 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. Limited Service Immediate Care services are non-emergency and non-urgent services. Services are provided in Limited Service Immediate Care Centers, which are mini-medical office chains typically staffed by nurse practitioners with an on-call physician. Examples of common ailments for which a reasonable, prudent layperson who possesses an average knowledge of health and medicine would seek Limited Service Immediate Care, include but are not limited to: ear, bladder, and sinus infections; pink eye; flu; and strep throat.

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

A. Use of operating room and recovery room.

B. Use of special procedure rooms.

C. Anesthesia services and supplies.

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

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

F. Medical and surgical supplies.

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

2.3 Coverage for Infertility Services.

Benefits are available for the diagnosis and treatment of infertility including Medically Necessary, non-Experimental/Investigational artificial insemination/intrauterine insemination and in-vitro fertilization. The oocytes (eggs) must be naturally produced by the Subscriber or spouse and fertilized with sperm naturally produced by the Subscriber or spouse. Prior authorization is required.

Subject to the Exclusions and Limitations, in-vitro fertilization benefits are available when each of the following are present:

A. The Member has had a fertility examination that resulted in a qualified physician's diagnosis of infertility including, but not limited to, any of the following medical conditions:

1. Endometriosis;

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

3. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy), or,

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

B. The Member has not been able to attain a successful pregnancy through a less costly infertility treatment for which coverage is available.

2.4 Organ and Tissue Transplants

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

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 BlueChoice.

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

3. Cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of 18 years) to and from the site of the transplant. Benefits are limited to $150 per day up to $10,000 maximum.

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

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

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

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

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

A. Definitions.

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

1. The National Cancer Institute Clinical Cooperative Group;

2. The National Cancer Institute Community Clinical Oncology Program;

3. The Aids Clinical Trials Group; and,

4. The Community Programs For Clinical Research In Aids.

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

NIH is the National Institutes of Health.

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

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

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

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

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

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

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

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

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

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

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

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

   a. One of the National Institutes of Health, such as the National Cancer Institute (NCI); or
   b. An NIH Cooperative Group or an NIH Center; or

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

d. The federal Department of Veterans Affairs; or,

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

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

a. Experience;

b. Training; and,

c. Volume of patients treated to maintain expertise;

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

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

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

2.7 Maternity Benefits.

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

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

2. Coverage for a Hospital stay;

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

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

5. Newborn hearing screening prior to discharge.

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

1. For a mother and newborn child who have a shorter Hospital stay than that provided under Section 3.2.D, Number of Inpatient Hospital Days Covered, benefits will be provided for:

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

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

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

C. Birthing Classes. Birthing classes are covered, one course, per pregnancy at a CareFirst BlueChoice approved facility.

D. Elective abortions.

2.8 Morbid Obesity.

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

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

1. Greater than 40 kilograms per meter squared; or

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

C. As used above, body mass index (BMI) means a practical marker used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

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

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

2.10 Dental Services.

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

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

1. If the Member is:

a. Seven years of age or younger;

b. Developmentally or otherwise severely disabled; and

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

condition of the Member.

2. Or, if the Member is:

   a. Seventeen years of age or younger;

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

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

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

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

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

   a. A fully accredited specialist in pediatric dentistry;

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

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

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

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

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

2.11 Oral Surgery. Benefits include:

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

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

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

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

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

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

A. Reconstructive Breast Surgery includes:

1. Augmentation mammoplasty;

2. Reduction mammoplasty; and

3. Mastopexy.

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

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

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

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

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

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

2.15 Chlamydia and Human Papillomavirus Screening.

A. Definitions

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

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

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

B. Covered Services

1. An annual routine Chlamydia Screening Test for:

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

   b. Male Members who have Multiple Risk Factors.

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

2.16 Osteoporosis Prevention and Treatment Services.

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

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

C. Qualified Individual means:

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

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

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

4. An individual with primary hyperparathyroidism; or

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

SECTION 3
INPATIENT HOSPITAL SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In a Contracting Provider Hospital when admitted under the care of a PCP or by another Contracting Physician if referred by a PCP.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOSPITAL ADMISSIONS MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

3.1 Covered Inpatient Hospital Services. A Member will receive benefits for services listed below when admitted to a Contracting Provider Hospital under the care of a PCP or other Contracting Physician to whom the Member was referred. 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 BlueChoice).

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

1. Inpatient Contracting Physician visits;
2. Consultations by Contracting Physician Specialists;
3. Intensive care services;
4. Rehabilitation Services;
5. Respiratory therapy, radiation therapy and chemotherapy services;
6. Anesthesia services and supplies;
7. Diagnostic procedures, laboratory tests and x-ray services;
8. Medically Necessary Ancillary Services rendered to the Member.

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

1. The use of:
   a. Operating rooms;
   b. Treatment rooms; and
   c. Special equipment in the Hospital.

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

3. Medical and surgical supplies.

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

5. Surgically implanted Prosthetic devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants and pacemakers. Available benefits under this provision do not include items such as artificial limbs or eyes, Hearing Aids, or other external prosthetics, which may be provided under other provisions of the contract. See Section 9, Medical Devices and Supplies and Section 2.12, Reconstructive Breast Surgery.

6. Medical social services.

3.2 Number of Hospital Days Covered. Provided the conditions, including the requirements in Section 3.3 below are met and continue to be met, as determined by CareFirst BlueChoice, benefits for Inpatient Hospital Services will be provided as follows:

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

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

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

B. Inpatient Coverage Following a Mastectomy.
Coverage will be provided for a minimum hospital stay of not less than forty-eight (48) hours following a Mastectomy.

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 Contracting Provider, the Member may elect to stay less than the minimum prescribed above when appropriate.

D. Childbirth. Coverage will be provided for a minimum Hospital stay of not less than:

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

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

Prior authorization is not required for the minimum Hospital stays listed above.

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

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

E. Other Hospitalization. Hospitalization for Covered Services other than those described above, will also be provided subject to the provisions of Section 3.3, below.

3.3 Inpatient Hospital Pre-Admission Review. Coverage of inpatient Hospital services is subject to the requirements for pre-admission review, concurrent review and discharge planning for all covered hospitalizations. Such review and approval shall determine:

A. The need for hospitalization;

B. The appropriateness of the approved Hospital or facility requested;

C. The approved length of confinement in accordance with CareFirst BlueChoice-established criteria; and

D. Additional aspects such as second surgical opinion and/or pre-admission testing requirements;

E. Failure or refusal to comply with notice requirements and other CareFirst BlueChoice authorization and approval procedures may result in reduction of the Member's benefits or exclusion of services from coverage.

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

SECTION 4
SKILLED NURSING FACILITY SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In a Contracting Provider Skilled Nursing Facility when admitted under the care of a PCP or by another Contracting Physician when referred by a PCP.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

SKILLED NURSING FACILITY SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

4.1 Covered Skilled Nursing Facility Services. When the Member meets the conditions for coverage listed below in Section 4.2, the services listed below are available to Members in a Skilled Nursing Facility:

A. Room and board in a semiprivate room;

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

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

1. Use of special equipment in the facility;

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

4.2 Conditions for Coverage. Skilled Nursing Facility care must be authorized or approved by CareFirst BlueChoice as meeting the following conditions for coverage:

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

B. The Member must be under the care of his or her PCP or other physician to whom the Member was referred.

C. The admission to the Skilled Nursing Facility must be a substitute for a Hospital admission. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.

D. The Member requires Skilled Nursing Care or skilled rehabilitation services that are required on a daily basis and can only be provided on an inpatient basis. Skilled Nursing Care means non-Custodial Care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

4.3 Custodial Care Is Not Provided. Benefits will not be provided for any day in a Skilled Nursing Facility that CareFirst BlueChoice determines is primarily for Custodial Care.

A. Custodial Care means care that is:

1. Not directed to the cure of an illness or recovery from an accident; and
2. Mainly for meeting the activities of daily living, e.g. bathing, eating; and
3. Not routinely provided by a trained medical professional; and
4. May be provided by person without professional medical skills or professional medical training.

B. Services may be deemed Custodial Care even if:

1. A Member cannot self-administer the care;
2. No one in the Member's household can perform the services;
3. Ordered by a physician;
4. Necessary to maintain the Member's present condition; or
5. Covered by Medicare.

4.4 Number of Days of Care. Benefits will be provided up to the maximum day limit, if any stated in the Schedule of Benefits.

SECTION 5
HOME HEALTH SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In a Member's home by a Contracting Provider Home Health Agency when authorized or approved by CareFirst BlueChoice.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOME HEALTH SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

5.1 Covered Home Health Services. Services must be provided within the Service Area when requested by a PCP or other physician when duly referred. Benefits are provided for:

A. Part-time or intermittent home nursing care by or under the supervision of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);

B. Rehabilitation Services;

C. Part-time or intermittent home health aid services;

D. Drugs and medications directly administered to the patient during a covered home health visit and incidental Medical Supplies directly expended in the course of a covered home health visit. Drugs, medications and medical supplies for home use (other than as described above) and purchase or rental of durable medical equipment are not covered under this Section. (See Section 9, Medical Devices and Supplies. Benefits for self-administered prescription drugs may be available through an Attachment to the Contract.);

E. Diagnostic Tests and Laboratory Services ordered by the PCP or other physician to whom the Member was referred;

F. Services of a medical social worker.

5.2 Conditions for Coverage. Benefits are provided when a Member:

A. Is under the care of the PCP or other physician to whom the Member was referred;

B. Resides within the Service Area;

C. Is confined to home due to a medical condition;

D. Would otherwise be eligible for a Hospital, or Skilled Nursing Facility admission;

E. Requires Skilled Nursing Care or Rehabilitation Services in order to qualify for home health aide services or other types of home health care. Skilled Nursing Care means non-Custodial Care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

F. The Medical Necessity of home health services must be certified by CareFirst BlueChoice as meeting the criteria for coverage;

G. The need for home health services must not be custodial in nature.

H. Services of a home health aide, medical social worker or registered dietician may also be provided but must be under the supervision of a licensed professional (RN or LPN) nurse.

5.3 Number of Home Health Visits.

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

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

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

3. Benefits for home visits following the surgical removal of a testicle are not subject to Copayment or Coinsurance. Benefits for home visits following the surgical removal of a testicle are not subject to a Deductible.

B. Home Visits Following a Mastectomy.

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

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

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

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

3. Benefits for home visits following a Mastectomy are not subject to Copayment or Coinsurance. Benefits for home visits following a Mastectomy are not subject to a Deductible.

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

SECTION 6
HOSPICE CARE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
As an inpatient or outpatient of a Qualified Hospice Care Program, when authorized or approved by CareFirst BlueChoice.	Coverage for the services listed below. The coverage is subject to the limitations, if any, listed below or stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOSPICE CARE SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

6.1 Covered Hospice Care Services. Services are covered when provided by a Qualified Hospice Care Program. CareFirst BlueChoice will monitor the care for ongoing appropriateness. Benefits are provided for inpatient and outpatient care and include the following:

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

B. Medical social services for the terminally ill patient and his or her Immediate Family. Immediate Family means the patient's spouse, parents, siblings, grandparents, and children;

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

D. Non-Custodial home health visits;

E. Services, visits, medical/surgical equipment or supplies; including equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member;

F. Laboratory Tests and X-Ray Services;

G. Ambulance services, when Medically Necessary as determined by CareFirst BlueChoice;

H. Respite Care will be limited to 14 days per Hospice Eligibility Period. "Respite Care" means temporary care provided to the terminally ill Member to relieve the Family Caregiver from the daily care of the Member;

I. Home visits within the Service Area;

J. Inpatient care is limited to a maximum of 30 days;

K. Family Counseling will be provided for the Immediate Family and Family Caregiver before the death of the terminally ill Member when authorized or approved by CareFirst BlueChoice. Family Counseling means counseling given to the Immediate Family or Family Caregiver of the terminally ill Member for the purpose of learning to care for the Member and to adjust to the death of the Member. Family Caregiver means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill Member;

L. Bereavement Services will be provided for the Immediate Family or Family Caregiver of the Member for the 6-month period following the Member's death or fifteen (15) visits, whichever occurs first. Bereavement Counseling means counseling provided to the Immediate Family or Family Caregiver of the Member after the Member's death to help the Immediate Family or Family Caregiver cope with the Member's death;

6.2 Conditions for Coverage. Hospice Care Services must meet the following conditions:

A. The Member must have a life expectancy of six (6) months or less;

B. The Member's attending PCP or other referring physician must submit a written Hospice Care Services plan of treatment to CareFirst BlueChoice;

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

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

2. The immediate families or family caregivers of those individuals.

D. The Medical Necessity and continued appropriateness of Hospice Care Services must be authorized or approved by CareFirst BlueChoice as meeting the criteria for coverage.

6.3 Hospice Eligibility Period. Is the period of time that begins on the first date hospice services are rendered and will terminate one hundred eighty (180) days later or on the death of the terminally ill Member, whichever first occurs. Any extension of the Hospice Eligibility Period must be authorized or approved by CareFirst BlueChoice. If CareFirst BlueChoice determines, based on grounds of Medical Necessity, that the benefit eligibility period should be extended, eligibility will be continued for up to thirty (30) additional days of outpatient services or fourteen (14) additional days of inpatient care.

SECTION 7
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In Contracting Physician's offices or other CareFirst BlueChoice approved facilities, or	Coverage for the services listed below.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.
In a CareFirst BlueChoice approved Hospital or Qualified Substance Abuse Treatment Facility when admitted under the care of a Contracting Physician.	Coverage for the services listed below.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOSPITALIZATION MUST BE AUTHORIZED OR APPROVED BY THE MENTAL HEALTH AND SUBSTANCE ABUSE MANAGEMENT PROGRAM

7.1 Definitions.

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

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

C. **Partial Hospitalization** means the provision of medically directed intensive or intermediate short-term treatment for mental illness, emotional disorders, drug abuse or alcohol abuse for a period of less than 24 hours but more than 4 hours in a day for a Member or Subscriber in a licensed or certified facility or program.

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

7.2 Outpatient Mental Health and Substance Abuse Services. Outpatient services must be obtained from Contracting Providers Coverage of Partial Hospitalization is subject to certification under the Mental Health Management Program of the need for treatment in a Partial Hospitalization program and the duration of such treatment.

A. Coverage of mental illness, emotional disorders, and alcohol abuse and drug abuse services includes evaluation, diagnosis and treatment of acute and non-acute conditions.

B. Medication management visits in connection with mental illness, emotional disorders, alcohol abuse or drug abuse will be covered in the same manner as medication management visits for physical illnesses. Prior authorization is not required for Methadone Maintenance Treatment.

C. Coverage of substance abuse and related mental health conditions include detoxification and rehabilitative services in a CareFirst BlueChoice designated program.

D. Other covered medical and medical Ancillary Services will be covered for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

E. Coverage for psychological and neuropsychological testing is provided for outpatient services to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse including psychological and neuropsychological testing for psychological diagnostic purposes. Services include evaluation, diagnosis and treatment of acute and non-acute conditions.

7.3 Inpatient Mental Health and Substance Abuse Services. Covered Services include the following:

A. Services for care and treatment of mental illness, emotional disorders, alcohol abuse or drug abuse, which, in the judgment of CareFirst BlueChoice, are Medically Necessary and treatable through inpatient hospitalization. Inpatient care is not covered if, in CareFirst BlueChoice's judgment, the condition and/or the treatment to be provided does not meet the criteria established by CareFirst BlueChoice for admission to a Hospital. Hospitalization in a specialized facility that is not a CareFirst BlueChoice approved facility is not covered;

B. Diagnosis and treatment for the abuse of or addiction to alcohol and drugs, including inpatient detoxification and rehabilitative services in an acute care Hospital or Qualified Substance Abuse Treatment Facility. A Member must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by CareFirst BlueChoice;

C. Visits to the patient in the Hospital or facility by Contracting Physicians and Contracting Providers;

D. Other covered medical and medical Ancillary Services will be covered for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

7.4 Residential Crisis Services

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

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

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

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

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

SECTION 8
EMERGENCY SERVICES AND URGENT CARE

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
At Contracting Provider Urgent Care Facilities and at Hospital emergency rooms and Urgent Care Facilities in or out of the Service Area.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

8.1 Definitions.

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

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

1. Serious jeopardy to the mental or physical health of the individual; or
2. Danger of serious impairment of the individual's bodily functions; or
3. Serious dysfunction of any of the individual's bodily organs; or
4. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as CareFirst BlueChoice determines.

8.2 Emergency Services and Urgent Care.

A. Benefits are available to a Member for Emergency Services and Urgent Care twenty-four (24) hours per day. Benefits for Emergency Services, Urgent Care and follow-up care after emergency surgery are provided regardless of whether the services are rendered inside or outside of the Service Area.

If a Member requires care while traveling or temporarily residing outside the Service Area, the Member must follow the emergency procedures established by CareFirst BlueChoice. In the case of travel or temporary residence outside the Service Area, benefits will be paid or provided for expenses incurred for treatment of an illness or injury only if:

1. The need for care could not reasonably have been foreseen before departing the Service Area or sufficiently in advance so as to permit the Member to return to the Service Area for the care before it became urgent;
2. The care was urgently required to alleviate acute pain or prevent further significant deterioration of the Member's condition;

3. The Member could not, without medically harmful results, return to the Service Area to receive treatment;

4. CareFirst BlueChoice determines that the travel was for some purpose other than the receipt of medical treatment; and,

5. CareFirst BlueChoice determines that the services were Medically Necessary.

B. In the case of a Hospital that has an emergency department, benefits include:

1. Appropriate medical screening;

2. Assessment and stabilization services; and

3. Ancillary Services routinely available to the emergency department, to determine whether or not an Emergency condition exists.

C. A provider is not required to obtain prior authorization or approval from CareFirst BlueChoice in order to obtain reimbursement for Emergency Services, Urgent Care or follow-up care after emergency surgery.

D. A Hospital, or other provider, or CareFirst BlueChoice, when CareFirst BlueChoice has reimbursed the provider, may attempt to collect payment from a Member for health care services that do not meet the criteria for Emergency Services.

E. Except as provided below, benefits are not provided for routine follow-up treatment within the Service Area provided by non- Contracting Providers. Follow-up treatment outside of the Service Area is covered if required in connection with a covered out-of-area Emergency or Urgent Care and CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care.

F. Benefits also include 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.

8.3 Notice to CareFirst BlueChoice in the event of an Emergency.

A. If the Member is admitted to a Hospital as a result of an Emergency, CareFirst BlueChoice must be notified the earlier of:

1. The end of the first business day after first receiving the care; or

2. Within 48 hours after first receiving the care.

B. If it was not reasonably possible to give notice, this requirement will be met if notice was given as soon as reasonably possible. The Member must provide information about the Emergency and the care received. If the Member does not return to the Service Area and transfer care to a Contracting Physician or Contracting Provider as soon as, in the judgment of CareFirst BlueChoice, the Member was able to do so without medically harmful results, no further benefits will be provided for services received on or after such date.

8.4 Ambulance Services.

A. Benefits are available for Medically Necessary air transportation and ground ambulance services as authorized and approved by CareFirst BlueChoice.

B. If a Member is outside of the United States and requires treatment for Emergency Services, benefits are provided for Medically Necessary air and ground transportation to the nearest facility where appropriate medical care is available.

8.5 Follow-up Care after Emergency Surgery. If CareFirst BlueChoice authorizes, directs, refers, or otherwise allows a Member to access a Hospital emergency facility or other urgent care facility for a medical condition that meets the criteria for Medical Emergency, as defined in the Contract, and requires emergency surgery:

A. Coverage shall be provided for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's PCP; and

B. The Member will be responsible for the same copayment for each follow-up visit as would be required for a visit to a Contracting Physician for specialty care.

SECTION 9
MEDICAL DEVICES AND SUPPLIES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
Medical Devices and Supplies obtained through designated Contracting Providers when authorized or approved by CareFirst BlueChoice.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

9.1 Covered Benefits. Benefits will be provided for Medical Devices and Supplies when:

A. Obtained from a designated Contracting Provider; and

B. The Member has coverage under the Contract at the time that the Durable Medical Equipment, Prosthetic, Orthotic Device, or Medical Supply is prescribed and received. The Member must continue to be eligible for coverage for the duration of time for which Durable Medical Equipment is rented.

9.2 Authorization or Approval of Medical Devices and Supplies by CareFirst BlueChoice. Benefits are limited to the least expensive Medically Necessary Durable Medical Equipment, Medical Supply, Orthotic Device or Prosthetic adequate to meet the patient's medical needs.

To qualify for coverage for Medical Devices, the Member or the provider must contact CareFirst BlueChoice prior to the purchase or rental of any Medical Device to obtain prior authorization-of such purchase or rental. CareFirst BlueChoice will determine the Medical Necessity for the covered Medical Device and the appropriateness of the type of appliance, device, equipment or supply requested. CareFirst BlueChoice will then recommend the Contracting Provider from whom the Member is authorized to obtain the Medical Device in order to receive benefits. Failure to contact CareFirst BlueChoice in advance of the purchase or rental and/or failure and refusal to comply with the authorization given by CareFirst BlueChoice will result in exclusion of the Medical Device from coverage.

9.3 Responsibility of CareFirst BlueChoice. CareFirst BlueChoice will not be liable for any claim, injury, demand or judgment based on tort or other grounds (including express or implied warranty of equipment) arising out of or in connection with the rental, sale, use, maintenance or repair of a Medical Device.

9.4 Definitions.

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

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

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

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

D. **Low Protein Modified Food Product** means a food product that is:

1. Specially formulated to have less than 1 gram of protein per serving; and

2. Intended to be used under the direction of a physician for the dietary treatment of an Inherited Metabolic Disease.

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

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

F. **Medical Food** means a food that is:

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

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

G. **Medical Supply** means items that:

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

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

3. Are ordered or prescribed by a physician or other qualified practitioner;

4. Are consistent with the diagnosis;

5. Are appropriate for use in the home;

6. Cannot withstand repeated use;

7. Are usually disposable in nature.

H. **Orthotic Device** means items that:

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

2. Are prescribed by a Health Care Provider;

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

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

5. Include devices necessary for post-operative healing.

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

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

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

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

4. Is prescribed by a Health Care Provider; and

5. Is removable and attached externally to the body.

9.5 Covered Services.

A. **Durable Medical Equipment**

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

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

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

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

C. **Medical Foods and Low Protein Modified Food Products**
Medical Foods and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases if the Medical Foods or Low Protein Modified Food Products are:

1. Prescribed as Medically Necessary for the therapeutic treatment of Inherited Metabolic Diseases; and;

2. Administered under the direction of a physician.

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

D. **Medical Supplies**

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

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

2. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and

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

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

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

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

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

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

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

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

9.7 Exclusions. Specific exclusions related to Medical Devices and Supplies are listed with the Exclusions and Limitations at the end of this Description of Covered Services.

SECTION 10
VISION CARE SERVICES

This Section contains certain terms that have a specific meaning as to Vision Care benefits. These terms are capitalized and are defined in 10.2 below, or in the Program Description.

This Section contains specific exclusions and limitations applicable to Vision Care benefits that are in addition to the exclusions and limitations contained in the Program Description.

10.1 General Provisions.

A. CareFirst has contracted with Davis Vision, Inc., a national provider of Vision Care services, to administer Vision Care benefits. Davis Vision, Inc. has special agreements with optometrists and ophthalmologists to provide Vision Care benefits to Members. These optometrists and ophthalmologists are Contracting Providers.

Davis Vision, Inc. is an independent company and administers the Vision Care Services on behalf of CareFirst BlueChoice.

B. Benefits for routine Vision Care are limited to the services listed in this Section.

C. To receive benefits under this Section, the Member is required to receive Vision Care from a Contracting Provider.

D. The Member's responsibility for covered Vision Care is stated in Section 10.5, Schedule of Benefits. In addition, the Member will be responsible for services, supplies or care which are not covered. Services, supplies or care that are not listed as Vision Care benefits or are listed as an exclusion are not Covered Services under this Section.

10.2 Definitions. In addition to the definitions contained in the Program Description, the underlined terms, below, when capitalized, have the following meanings:

Allowed Benefit in this Section only means:

For a Contracting Provider, the Allowed Benefit for a Covered Service is the lesser of:

a. The actual charge; or

b. The amount allowed for the service in effect on the date that the service is rendered.

The benefit payment is made directly to a Contracting Provider. When a Member receives a vision examination from a Contracting Provider, the benefit payment is accepted as payment in full, except for any applicable copayment. The Contracting Provider may collect any applicable copayment.

Benefit Period means the period of time during which covered Vision Care benefits are eligible for payment. The Benefit Period is on a contract year basis.

Contracting Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Vision Care is rendered when acting within the scope of such license; and, that has contracted with Davis Vision, Inc. to provide Vision Care in accordance with the terms of this Section.

Non-Contracting Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Vision Care is rendered when acting within the scope of such license; and, who does not have an agreement with Davis Vision, Inc. for the rendering of Vision Care. A Non-Contracting Provider under this Section may or may not have contracted with CareFirst. The Member should contact Davis Vision, Inc. for the current list of Contracting Providers.

Vision Care means those services for which benefits are provided under this Section.

10.3 What is Covered. Vision Examination. One vision examination per Benefit Period. A vision examination may include, but is not limited to:

A. Case history;
B. External examination of the eye and adnexa;
C. Ophthalmoscopic examination;
D. Determination of refractive status;
E. Binocular balancing test;
F. Tonometry test for glaucoma;
G. Gross visual field testing;
H. Color vision testing;
I. Summary finding; and,
J. Recommendation, including prescription of corrective lenses.

10.4 How It Is Covered. When the Member receives a vision examination from a Contracting Provider, the benefit payment is accepted as payment in full, except for any applicable copayment.

10.5 Schedule of Benefits.

SERVICE	MEMBER PAYS
Vision Examination	$10 when Member receives Covered Services from a Contracting Provider.

10.6 Exclusions. The following services are excluded from coverage:

A. Diagnostic services, except as listed in What is Covered.

B. Medical care or surgery. Covered Services related to medical conditions of the eye may be covered under the medical benefits Section of the Program Description.

C. Prescription drugs except as may be necessary for a vision exam.

D. Orthoptics, vision training and low vision aids.

E. Vision Care services for cosmetic use.

F. Frames, lenses, sunglasses or contact lenses.

G. Services obtained from Non-Contracting Providers.

SECTION 11
REFERRALS

11.1 Referral Requirements.

A. Benefits for services rendered by Contracting Physicians other than the PCP are only provided when prior written referral by a PCP is obtained for the specified Covered Service.

B. The exceptions to the PCP referral requirement are listed below in Section 11.2.

11.2 Exceptions to Requirement for PCP Referral. A Member may self-refer to Contracting Providers for:

A. Routine eye exams provided by a Contracting Provider optometrist or vision center. However, services provided by an ophthalmologist require a referral.

B. Except for infertility services, covered gynecological and obstetric services from a Contracting Provider certified nurse midwife or Contracting Provider Obstetrician/Gynecologist.

C. Covered Services rendered at Contracting Provider radiologist offices whether ordered by a Contracting Provider or non- Contracting Provider.

D. Covered Services rendered by Contracting Provider laboratory whether ordered by a Contracting Provider or a non-Contracting Provider.

E. Emergency and Urgent Care services as described in Section 8.

F. Covered Services that are directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an Oncologist, chemotherapy, and radiation therapy by Contracting Providers without a referral by the Member's Primary Care Provider. Benefits are subject to review and approval under utilization management requirements established by CareFirst BlueChoice. Contracting Providers will handle utilization management procedures on behalf of the Member.

G. Covered Services rendered by a Contracting Provider ophthalmologist.

Note: CareFirst BlueChoice reserves the right to make changes to the categories of providers or services that do not require a Primary Care Provider referral. Notice of such changes will be provided to the Member.

11.3 Standing or Condition Management Referral to a Specialist.

A. Definitions.

1. A **Condition Management Referral** is a referral that allows a Contracting Specialist to act as a PCP:

   a. Solely for the condition for which the Member was referred; and

   b. Only for the authorized treatment period.

   The Contracting Physician Specialist shall be permitted to provide and coordinate the primary and specialty care for the Member's condition and includes authorizing such referrals, procedures, tests, and other medical services as the Member's PCP would otherwise be permitted to provide or authorize.

2. A **Standing Referral** is a referral to a Contracting Physician Specialist that does not have a specified treatment period. The referral is subject to periodic review by the PCP and CareFirst BlueChoice to determine whether the Standing Referral continues to be Medically Necessary.

3. **Specialist** as used in this Section means a physician who is:

   a. Certified or eligible for certification by the appropriate specialty board; and

   b. Trained in practice in a specified field of medicine.

B. Condition Management Referral or Standing Referral to a Specialist.

1. A Member may request a Condition Management Referral or a Standing Referral from the PCP to a Contracting Physician Specialist for a condition that:

   a. Is life threatening, degenerative, chronic or disabling; or

   b. Requires a Specialist over a prolonged period of time.

2. Upon request for a referral, the PCP will contact CareFirst BlueChoice to obtain authorization.

C. Standing Referral for Cancer Patients.

1. A Member who has been diagnosed with cancer may request a Standing Referral from their PCP to a:

   a. Contracting Physician who is a board-certified physician in pain management; or

   b. Contracting Physician who is an oncologist.

2. A Standing Referral does not authorize the Contracting Physician to assume the responsibilities for care other than cancer care and pain management. The referral is subject to periodic review by the PCP and CareFirst BlueChoice.

D. Standing Referral for Pregnancy.

1. A Member who is pregnant may obtain a standing referral to an obstetrician.

2. After the Member who is pregnant receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with CareFirst BlueChoice's policies and procedures, through the postpartum period.

11.4 Conditions for a Referral to a Non-Contracting Specialist or Non-Contracting Nonphysician Specialist.

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

A Nonphysician Specialist means a Health Care Provider who:

1. is not a physician;

2. is licensed or certified under the Health Occupations Article of the Annotated Code of Maryland or the applicable licensing laws of any State or the District of Columbia; and

3. is certified or trained to treat or provide Covered Services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.

A Member may request a referral to a Specialist or Nonphysician Specialist who is not a Contracting Physician or Contracting Provider if:

1. The Member is diagnosed with a condition or disease that requires specialized medical care; and

   a. CareFirst BlueChoice does not contract with a Specialist or Nonphysician Specialist with the professional training and expertise to treat or provide Covered Services for the condition or disease; or

   b. CareFirst BlueChoice cannot provide reasonable access to a Specialist or Nonphysician Specialist with the professional training and expertise to treat or provide Covered Services for the condition or disease without unreasonable delay or travel.

2. The non-contracting Specialist or Nonphysician Specialist will be reimbursement the same as would be provided to a specialist who is a Contracting Physician or Contracting Provider. The Member may be subject to balance billing.

A decision by CareFirst BlueChoice not to provide access to or coverage of treatment by a Specialist in accordance with this section constitutes an Adverse Benefit Determination as defined in the Program Description, if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

11.5 Continuing Care with Terminated Providers.

A. When a Contracting Provider terminates their agreement with CareFirst BlueChoice, for any reason except for cause, benefits will be provided for continuing care rendered by the terminated provider as described in this Section. CareFirst BlueChoice will send a notice to the Member that the Contracting Provider is no longer available.

B. The Member may, upon request, continue to receive Covered Services from his/her PCP for up to 90 days after the date of the notice of the PCP's termination from CareFirst BlueChoice's provider panel, if termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status. In addition, a Member may continue treatment with a terminated provider if:

   1. A Member was in an active course of treatment with the terminated Contracting Provider prior to the date the Member was notified. The Member needs to request, from CareFirst BlueChoice, to continue receiving care from the terminated Contracting Provider. Benefits will be provided for a period of 90 days from the date the Member is notified by CareFirst BlueChoice that the terminated Contracting 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 Contracting 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 Contracting Provider's agreement terminated may continue to receive Covered Services directly related to the treatment of the terminal illness until the Member dies.

11.6 CareFirst BlueChoice Personnel Availability for Prior Authorization.

CareFirst BlueChoice requires prior authorization for certain medical treatment as stated in the Contract. Check the specific description of the Covered Services for a notice regarding prior authorization. CareFirst BlueChoice shall have personnel available to provide prior authorization at all times when such prior authorization is required.

SECTION 12
EXCLUSIONS AND LIMITATIONS

12.1 Coverage Is Not Provided For:

A. Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst BlueChoice.

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

This exclusion will not be used, however, to deny Patient Cost when a clinical trial meets the criteria stated in Section 2.

C. The cost of services that:

1. Are furnished without charge; or

2. Are normally furnished without charge to persons without health insurance coverage; or

3. Would have been furnished without charge if a Member was not covered under the Contract or under any health insurance.

D. Services that are not described as covered in the Contract or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a PCP and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are non-covered or do not otherwise meet the conditions and criteria for coverage.

E. Except for Emergency Services and Urgent Care, benefits will not be provided for any service(s) provided to a Member by non-Contracting Physicians or non-Contracting Providers, unless prior written authorization is specifically obtained from CareFirst BlueChoice.

F. Routine palliative, or Cosmetic foot care (except for conditions determined by CareFirst BlueChoice to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet.

G. Except for treatment for Accidental Injury or benefits for Oral Surgery as described, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies.

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

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

J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under this Contract. Medications that can be self-administered or do not medically require administration by or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility. Benefits for prescription drugs may be available through an Attachment to the Contract.

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

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

M. Services to reverse voluntary, surgically induced infertility, such as a reversal of sterilization.

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

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

P. Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.

Q. Services furnished as a result of a referral prohibited by law.

R. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst BlueChoice.

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

T. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.

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

V. Any service received at no charge to the Member in any federal Hospital or facility, or through any federal, state or local governmental agency or department, not including Medicaid. This exclusion does not apply to care received in a Veteran's Hospital or facility unless that care is rendered for a condition that is a result of the Member's military service.

W. Private duty nursing.

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

1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.

2. Administrative fees charged by a Health Care Provider to a Member to retain the Health Care Provider services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Contract are limited to Covered Services rendered to a Member by a Health Care Provider.

Y. Educational therapies intended to improve academic performance.

Z. Vocational rehabilitation and employment counseling.

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

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

CC. Oral surgery, dentistry or dental process unless otherwise stated.

DD. Treatment of temporomandibular joint disorders unless otherwise stated.

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

FF. Rehabilitative Services delivered through early intervention and school services.

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

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

12.2 Infertility Services.

Coverage will not be provided when:

A. The Member or spouse has undergone elective sterilization with or without reversal.

B. Any surrogate or gestational carrier is used.

C. The service involves the use of donor egg(s), donor sperm or donor embryo(s).

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

Coverage will not be provided for:

E. Cryopreservation, storage, and or thawing of sperm, egg(s), or embryo(s).

F. Any charges related in any way to the acquisition, maintenance, storage, examination, testing, sterilization or preservation of donor eggs and/or donor sperm.

12.3 Organ and Tissue Transplants. Coverage is not provided for:

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

B. Any Hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.

C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice.

D. Services for a Member who is an organ donor when the recipient is not a Member.

E. Benefits will not be provided for donor search services.

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

12.4 Inpatient Hospital Services. Coverage is not provided for:

A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.

B. Non-medical items and Convenience Items, such as television and phone rentals, guest trays and laundry charges.

C. Except for covered Emergency Services and Maternity Care, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private duty nursing.

12.5 Home Health Care Services. Coverage is not provided for:

A. Private duty nursing.

B. Custodial Care.

C. Services in the Member's home if it is outside the Service Area.

12.6 Hospice Benefits. Coverage is not provided for:

A. Services, visits, medical equipment or supplies that are not included in CareFirst BlueChoice-approved plan of treatment.

B. Services in the Member's home if it is outside the Service Area.

C. Financial and legal counseling.

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

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

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

G. Reimbursement for volunteer services.

H. Custodial Care, domestic or housekeeping services.

I. Meals on Wheels or similar food service arrangements.

J. Rental or purchase of renal dialysis equipment and supplies.

K. Private duty nursing.

12.7 Outpatient Mental Health and Substance Abuse. Coverage is not provided for:

A. Psychological testing, unless Medically Necessary, as determined by CareFirst BlueChoice, and appropriate within the scope of Covered Services.

B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.

C. Intellectual disability, after diagnosis.

D. Psychoanalysis.

12.8 Inpatient Mental Health and Substance. Coverage is not provided for:

A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.

B. Custodial Care.

C. Observation or isolation.

12.9 Emergency Services and Urgent Care. Coverage is not provided for:

A. Emergency care, if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).

B. Medical services rendered outside of the Service Area that could have been foreseen by the Member prior to departing the Service Area.

C. Charges for Emergency and Urgent Care services received from a non-Contracting Provider after the Member could reasonably be expected to travel to the nearest Contracting Provider.

D. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the Emergency or Urgent Care facility outside of the Service Area unless CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care.

E. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.

F. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency as defined in Section 8.

12.10 Medical Devices and Supplies. Coverage is not provided for:

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

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

C. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoyer/stair lifts, ramps, shower/bath bench.

D. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.

E. 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.

F. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.

G. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

H. Eyeglasses, contact lenses, dental prostheses or appliances, or Hearing Aids (except as otherwise provided herein for minor children). Benefits for eyeglasses and contact lenses may be available through an Attachment to or included as a separate Section within the Contract.

I. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.

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

SECTION 13
SCHEDULE OF BENEFITS

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

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

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
SECTION 2 – OUTPATIENT AND OFFICE SERVICES		
Outpatient Medical Services		
Office Visits	Office visits to CareFirst BlueChoice Specialist requires written referral from Primary Care Physician (PCP), except as otherwise provided in the Contract	$5 per visit (PCP) $10 per visit (Specialist)
Laboratory Tests and X-rays		No copayment or coinsurance
Other Diagnostic Testing		$5 per visit (PCP) $10 per visit (Specialist)
Preventive Services		
Well Child Care		$5 per visit (PCP) $10 per visit (Specialist)
Immunizations		No copayment or coinsurance
Diagnostic services		
Hospital Outpatient professional practitioner		No copayment or coinsurance
Office		$5 per visit (PCP) $10 per visit (Specialist)
Routine GYN Exam	Limited to one visit per Benefit Period	$5 per visit (PCP) $10 per visit (Specialist)

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
Adult Preventive Care	Limited to one visit per Benefit Period	$5 per visit (PCP) $10 per visit (Specialist)
Immunizations		No copayment or coinsurance
Diagnostic services		
Hospital		No copayment or coinsurance
Outpatient professional practitioner		
Office		$5 per visit (PCP) $10 per visit (Specialist)
Human Papillomavirus Screening		
Hospital		No copayment or coinsurance
Outpatient professional practitioner		
Office		$5 per visit (PCP) $10 per visit (Specialist)
Chlamydia Screening		
Hospital	Limited to one visit per Benefit Period	No copayment or coinsurance
Outpatient professional practitioner		
Office		$5 per visit (PCP) $10 per visit (Specialist)
Osteoporosis prevention		
Hospital		No copayment or coinsurance
Outpatient professional practitioner		
Office		$5 per visit (PCP) $10 per visit (Specialist)

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
Cancer Screening Tests		
Prostate Cancer Screening		
Hospital	As described in Section 2.1	No copayment or coinsurance
Outpatient professional practitioner		
Office	As described in Section 2.1	$5 per visit (PCP) $10 per visit (Specialist)
Colorectal Cancer Screening		
Hospital	As described in Section 2.1	No copayment or coinsurance
Outpatient professional practitioner		
Office		$5 per visit (PCP) $10 per visit (Specialist)
Breast Cancer Screening	At a minimum, benefits will be provided in accordance with the latest guidelines issued by the American Cancer Society. unlimited	No copayment or coinsurance
Allergy Treatment	Number of visits not limited	$5 per visit (PCP) $10 per visit (Specialist)
Dental Services Related to Accidental Injury		No copayment or coinsurance
Eye Care Services		
Medical Treatment		$5 per visit (PCP) $10 per visit (Specialist)
Rehabilitation Services (includes Physical Therapy, Occupational Therapy and Speech Therapy)		
Hospital	Limited to 30 combined visits per condition per Benefit Period	No copayment or coinsurance
Outpatient professional practitioner		$10 per visit (Specialist)
Office		
Spinal Manipulation Services	Limited to 20 visits per Condition per Benefit Period Benefits for spinal manipulation services are limited to Members who are twelve (12) years of age or older	$10 per visit (Specialist)
Cardiac Rehabilitation		No copayment or coinsurance

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
Habilitative Services		
Hospital	Limited to Members under age 19 Therapy maximums do not apply	No copayment or coinsurance
Outpatient professional practitioner		$10 per visit (Specialist)
Office		
Chemotherapy		
Hospital		No copayment or coinsurance
Outpatient professional practitioner		10 per visit (Specialist)
Office		
Renal Dialysis		No copayment or coinsurance
Maternity Care	The Member maximum payment per pregnancy by a Primary Care Physician (PCP) or Specialist applies only to maternity care performed by the Member's attending obstetrician(s).	$50 per pregnancy or $5 per PCP office visit up to Member maximum payment of $50 $100 per pregnancy or $10 per Specialist office visit up to Member maximum payment of $100
Infertility Services		
Artificial Insemination		50% of the Allowed Benefit
In-Vitro Fertilization	Limited to 3 attempts per live birth up to a lifetime maximum CareFirst BlueChoice payment of $100,000.	50% of the Allowed Benefit
Outpatient Hospital or ambulatory care facility		No copayment or coinsurance
Outpatient medical and surgical professional services provided at an outpatient Hospital or ambulatory care facility		$5 per visit (PCP) $10 per visit (Specialist)
SECTION 3 – INPATIENT HOSPITAL SERVICES		
Inpatient Facility (medical or surgical condition, including maternity)		No copayment or coinsurance
Inpatient Facility (Rehabilitation Services)	Limited to 90 days per Benefit Period	No copayment or coinsurance

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
Professional Services (medical or surgical condition, including maternity)		No copayment or coinsurance
SECTION 4 – SKILLED NURSING FACILITY SERVICES		
	Number of covered days not limited	No copayment or coinsurance
SECTION 5 – HOME HEALTH CARE SERVICES		
	Number of visits not limited	No copayment or coinsurance
Postpartum Home Visits		No copayment or coinsurance
Home visits following childbirth, Home visits following the surgical removal of a testicle		No copayment or coinsurance
SECTION 6 – HOSPICE CARE SERVICES		
Hospice Care	Limited to the Hospice Eligibility Period. See Section 6.3.	
Inpatient Care	Limited to 30 days per Member per lifetime	No copayment or coinsurance
Outpatient Care	Unlimited visits during Hospice Eligibility Period.	No copayment or coinsurance
Respite Care	Limited to 14 days per Hospice Eligibility Period	No copayment or coinsurance
Bereavement Services	Limited to the 6-month period following patient's death or 15 visits whichever first occurs	No copayment or coinsurance
SECTION 7 – MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Services		
Office visit to Contracting Provider Office, including psychological testing	Number of visits not limited	$5 per visit
Other outpatient facility,	Number of visits not limited	No copayment or coinsurance
Office Visits for Medication Management	Number of visits not limited	$5 per visit

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
Partial Hospitalization Program		
Hospital	Number of visits not limited	No copayment or coinsurance
Outpatient professional practitioner	Number of visits not limited	$5 per visit
Methadone Maintenance Treatment		
Hospital	The Member payment will not be greater than 50% of its daily cost	No copayment or coinsurance
Outpatient professional practitioner	The Member payment will not be greater than 50% of its daily cost	$5 per visit
Office		
Psychological testing and Neuro-psychological testing for diagnostic purposes		
Hospital		No copayment or coinsurance
Outpatient professional practitioner		$5 per visit
Office		
Inpatient Services		
Hospital or Facility Services	Number of days not limited	No copayment or coinsurance
Professional Services		No copayment or coinsurance
Residential Crisis Services		
Facility Services	Number of days not limited	No copayment or coinsurance
Professional Services		No copayment or coinsurance

SECTION 8 – EMERGENCY SERVICES AND URGENT CARE		
Contracting Provider Urgent Care Facility	Limited to Emergency Services or unexpected, urgently required services.	No copayment or coinsurance
Hospital Emergency Room or Non-Contracting Urgent Care Facility	Limited to Emergency Services or unexpected, urgently required services.	$25 per visit, waived if admitted as inpatient
Other Emergency Services or urgently required services provided by a non-Contracting Physician		
Outpatient professional practitioner	Limited to unexpected, urgently required services	No copayment or coinsurance
Office	Limited to unexpected, urgently required services	$5 per visit (PCP) $10 per visit (Specialist)
Ambulance Services		No copayment or coinsurance
HIV Screening		
Hospital		No copayment or coinsurance
Outpatient professional practitioner		
Office		$5 per visit (PCP) $10 per visit (Specialist)

SERVICE	LIMIT ON BENEFITS	MEMBER PAYMENT
SECTION 9 – MEDICAL DEVICES AND SUPPLIES		
		No copayment or coinsurance
Hair Prosthesis		
Hair Prosthesis	Limited to a maximum CareFirst BlueChoice payment of $350 for one hair prosthesis per Benefit Period.	No copayment or coinsurance
Hearing Aids for Minor Children		
Hearing Aid	Limited to one Hearing Aid for each hearing impaired ear every 36 months.	No copayment or coinsurance
Related Services		Benefits are available to the same extent as benefits provided for other illnesses
Medical Foods and Nutritional Substances		
	The maximum annual limit does not apply	No copayment or coinsurance

MAXIMUM ANNUAL COPAYMENTS AND COINSURANCE	
If the Group offering includes **four** Types of Coverage, the Maximum Annual Copayments and Coinsurance are:	
Individual*	$2,000*
Individual and Child	$4,000
Individual and Adult	$4,000
Family	$6,000

* If Coverage is complementary to Medicare, the Maximum Annual Copayment and Coinsurance is $1,300.

Except as provided below, total Copayments and Coinsurance paid during a Benefit Period by a Subscriber and, if applicable, his or her Dependents are subject to the Maximum Annual Copayment established for the type of coverage in which the Member is enrolled (e.g. Individual or Family) as stated above. The Maximum Annual Copayment and Coinsurance applies on a Benefit Period basis even though the Member may have been enrolled for less than Benefit Period.

If the Subscriber is enrolled under Family coverage or, if applicable, Two-Party coverage (Individual and Adult or Individual and Child) the Member can meet the Maximum Annual Copayment and Coinsurance if individual Copayments and Coinsurance exceed the Maximum Annual Copayment and Coinsurance established for Individual coverage. In addition, if the total Copayments of all covered family members exceed the Maximum Annual Copayment and Coinsurance for the type of coverage enrolled, all covered family members will be deemed to have met the Maximum Annual Copayment and Coinsurance. However, an individual family member cannot contribute more than the Maximum Annual Copayment and Coinsurance for Individual Coverage.

CareFirst BlueChoice will notify the Member if the Maximum Annual Copayment and Coinsurance is reached, based on billing and claims information in our records. If the Member satisfies the Maximum Annual Copayment and Coinsurance, the Member will be entitled to a refund of any excess Copayments and Coinsurance paid and, for the remainder of that Benefit Period, will not be required to pay additional Copayments and Coinsurance for services that are subject to the Maximum Annual Copayment and Coinsurance.

The Maximum Annual Copayment and Coinsurance limit does not apply to charges or Copayments and Coinsurance in connection with any of the following:

- Charges for services which are not covered under this Contract or which exceed the maximum number of covered visits/days under the Member's coverage.
- Copayments required under any Attachments to this Contract, unless the Attachment specifically states otherwise.
- Coinsurance or Copayments for services covered under Section 10 VISION SERVICES

ATTACHMENT B
DESCRIPTION OF COVERED SERVICES
PRESCRIPTION DRUG PROGRAM

This Attachment contains specific benefits, exclusions, limitations and general provisions applicable to the Prescription Drug Program. The exclusions, limitations and general provisions are in addition to those contained in the Program Description and other Attachments.

The Prescription Drug Program is included in the coverage of all Members. To qualify for these benefits, Eligible Employee/Members and Dependents must enroll in the BlueChoice Program Option.

Members are required in all instances, except in the case of Emergency Services or an out-of-area Urgent Care situation, to receive Prescription Drugs from a Contracting Provider.

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SECTION 1
DEFINITIONS

In addition to the definitions contained in the Description of Covered Services Attachment B, the underlined terms, below, when capitalized, have the following meanings:

Allowed Benefit, as used in this Attachment, means:

The Allowed Benefit for covered Prescription Drugs is the lesser of:

1. The Pharmacy's actual charge; or

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

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

If the Member purchases a covered Prescription Drug or Diabetic Supply from a non-Contracting Pharmacy, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst BlueChoice or its designee up to the amount of the Allowed Benefit, minus any applicable Copayment. Members may be responsible for balances above the Allowed Benefit.

Brand Name Drug means a Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and that may be used and protected by a trademark.

Contracting Provider, as used in this Attachment, means the separate independent Pharmacist or Pharmacy that has contracted with CareFirst BlueChoice or its designee to provide Prescription Drugs in accordance with the terms of this Attachment.

Copayment (Copay), as used in this Attachment, means a fixed dollar amount that a Member must pay for certain covered Prescription Drugs.

Diabetic Supplies means all Medically Necessary and appropriate supplies prescribed by a health care provider for the treatment of diabetes.

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

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

Over-the-Counter, as used in this Attachment, means medications and supplies that may be purchased without a prescription.

Pharmacist means an individual licensed to practice pharmacy regardless of the location where the activities of practice are performed.

Pharmacy means an establishment in which prescription or nonprescription drugs or devices are compounded, dispensed, or distributed.

Preferred Brand Name Drug means a Brand Name Drug that is included on CareFirst BlueChoice's Preferred Drug List.

Preferred Drug List means the list of Brand Name Drugs and Generic Drugs issued by CareFirst BlueChoice and used by providers when writing and Pharmacists when filling prescriptions. All Generic Drugs are included in the Preferred Drug List. Not all Brand Name Drugs are included in the Preferred Drug List. CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Preferred Drug List is available to the Member upon request.

Prescription Drug means a drug, biological or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;" and, drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature. For purposes of this Attachment, Prescription Drug also includes Diabetic Supplies.

Prior Authorization List means the limited list of Prescription Drugs issued by CareFirst BlueChoice for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from CareFirst BlueChoice. A copy of the Prior Authorization List is available to the Member upon request.

SECTION 2
PRESCRIPTION DRUG BENEFITS

2.1 Benefits will be provided for a Prescription Drug dispensed by a Contracting Provider for self-administered-use on an outpatient basis for the treatment of a condition for which benefits are provided under the terms of the Description of Covered Services or an Attachment.

2.2 CareFirst BlueChoice or its designee reserves the right to substitute a Generic Drug for any Brand Name Drug unless otherwise indicated on the prescription order.

2.3 Members may obtain up to a thirty-four (34) day supply of a Prescription Drug from a Contracting Provider, and up to a ninety (90) day supply of a Maintenance Drug, via retail or through the mail order program described in Section 3, Mail Order Program. Members must use 75% of a dispensed non-Maintenance Drug or Maintenance Drug in the manner prescribed before a refill of that prescription can be obtained.

2.4 A Member may select a Prescription Drug that is not included on the Preferred Drug List. However, if a Member selects a Prescription Drug not included on the Preferred Drug List when a Prescription Drug on the Preferred Drug List is available, the Member will pay the non-Preferred Brand Name Drug Copayment.

2.5 Providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Prescription Drug on the Prior Authorization List. A copy of the Prior Authorization List is available to the Member or Provider upon request.

2.6 In cases of Emergency Services or Out-of-Area Urgent Care situations, if the Member purchases a covered Prescription Drug from a non-Contracting Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst BlueChoice or its designee in the amount of the Allowed Benefit, minus any applicable Copayment. Members may be responsible for balances above the Allowed Benefit.

2.7 Benefits include:

A. Any contraceptive drug or device that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. Coverage for procedures for insertion or removal and any Medically Necessary examinations associated with the use of such contraceptive drugs or devices shall be provided under the medical benefits outlined in the Description of Covered Services to which this Attachment is attached.

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. Coverage is not provided for a drug that may be obtained Over-the-Counter without a prescription.

Nicotine Replacement Therapy. Nicotine Replacement Therapy means a product that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber. Nicotine Replacement Therapy does not include any Over-the-Counter product that may be obtained without a prescription. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.

D. Injectable medications that are self-administered and the prescribed syringes.

E. Standard covered items such as insulin, glucagon and anaphylaxis kits.

F. Fluoride products.

G. Diabetic Supplies.

H. Infertility drugs and agents.

SECTION 3
MAIL ORDER PROGRAM

All Members have the option of ordering Prescription Drugs via mail order. Members ordering Prescription Drugs through the mail order program will be entitled to a thirty-four (34) day supply for non-Maintenance Drugs and a ninety (90) day supply for Maintenance Drugs. For non-Maintenance Drugs there is one Copayment due for each thirty-four (34) day supply. For Maintenance Drugs there is one Copayment for the first thirty-four (34) day supply and two Copayments for a supply of thirty-five (35) days or more. Members will be responsible for the Copayments as outlined in Section 4 Copayments.

SECTION 4
COPAYMENTS

4.1 The Member must pay the Copayment at the time that a prescription is filled by the Pharmacist.

4.2 For Prescription Drugs purchased in a Pharmacy or purchased through the mail order program, there is one Copayment due for each thirty-four (34) day supply. For Maintenance Drugs, a Member may receive up to a ninety (90) daysupply provided the Member pays one Copayment for the first thirty-four (34) day supply plus two Copayments for a supply of thirty-five (35) days or more.

4.3 The Copayment is:

A. Generic Drug: $5 per prescription or refill.

B. Preferred Brand Name Drug: $20 per prescription or refill.

C. Non-Preferred Brand Name Drug: $35 per prescription or refill.

D. If the cost of the Prescription Drug is less than the Copayment, then the cost of the Prescription Drug will be payable by the Member at the time the prescription is filled.

E. Diabetic Supplies are not subject to any Copayments or Coinsurance.

SECTION 5
EXCLUSIONS

Benefits will not be provided under this Attachment for:

5.1 Any devices, appliances, supplies, and equipment except as otherwise provided in Section 2 in this Attachment.

5.2 Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.

5.3 Prescription Drugs for cosmetic use.

5.4 Prescription Drugs administered by a physician or dispensed in a physician's office.

5.5 Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst BlueChoice.

5.6 Drugs or medications lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a prescription (Over-the-Counter medications).

5.7 Vitamins, except CareFirst BlueChoice will provide a benefit for Prescription Drug:
- A. prenatal vitamins.
- B. fluoride and fluoride containing vitamins.
- C. single entity vitamins, such as Rocaltrol and DHT.

5.8 Any portion of a Prescription Drug that exceeds:
- A. a thirty-four (34) day supply for Prescription Drugs; or,
- B. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst BlueChoice.

5.9 Prescription Drugs that are administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not a patient in the health care facility.

5.10 Prescription Drugs for weight loss.

5.11 Biologicals and allergy extracts.

5.12 Blood and blood products. (May be covered under the medical benefits in the Description of Covered Services to which this Attachment is attached.)

SECTION 6
GENERAL PROVISIONS

6.1 As a condition precedent to the approval of claims hereunder, each Member authorizes and directs any Pharmacy that furnishes Prescription Drugs hereunder to make available to CareFirst BlueChoice or its designee information relating to such benefits, copies of records thereof, and such other information and records as may be needed by CareFirst BlueChoice or its designee. CareFirst BlueChoice or its designee will in every case hold such information and records as confidential.

6.2 CareFirst BlueChoice or its designee will not be liable for any claim or demand for injury or damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any Prescription Drug or any other item whether or not covered under this Contract.

6.3 The Employee/Member's current identification card must be presented when a Member purchases Prescription Drugs at a Contracting Provider to receive the maximum amount of benefits under this Program. If the Member fails to present his identification card, the Member may be responsible for charges above the Allowed Benefit.

6.4 The Prescription Drug Program carries no conversion privileges.