Charles County Commissioners

Preferred Provider Option
Prescription Drug

CareFirst of Maryland, Inc.

doing business as

CareFirst BlueCross BlueShield

10455 Mill Run Circle
Owings Mills, MD 21117-5559

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

EVIDENCE OF COVERAGE

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

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

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

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

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

Group Name: Charles County Commissioners
Preferred Provider Option; Prescription Drug

Account Number(s): 66794

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DEFINITIONS

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

Allowed Benefit means:

1. Contracted Health Care 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. For a Health Care Provider that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is, as follows:

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

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

3. Non-contracted Emergency Services Health Care Provider: CareFirst shall pay the greater of the following amounts for Emergency Services received from a non-contracted Emergency Services Health Care Provider:

    a. The Allowed Benefit stated in paragraph 2., above.

    b. The amount negotiated with Contracted Health Care Providers for the Emergency Service provided, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider. If there is more than one amount negotiated with Contracted Health Care Providers for the Emergency Service provided, the amount paid shall be the median of these negotiated amounts, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

    c. The amount for the Emergency Service calculated using the same method CareFirst generally used to determine payments for services provided by a Non-Contracted Health Care Provider, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

d. The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Service, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Health Care Provider.

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

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

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period is: January 1st through December 31st.

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

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

Claims Administrator means CareFirst.

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

Comprehensive Rehabilitation Facility means any person that provides or holds himself out as providing Comprehensive Physical Rehabilitation Services on an outpatient basis; or a hospital that is licensed as a special Rehabilitative Services hospital.

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

1. Includes evaluation and treatment; and

2. Incorporates:

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

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

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

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

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

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

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

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

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

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

1. Financial dependency on an individual covered under the Contract;
2. Marital status;
3. Residency with an individual covered under the Contract;
4. Student status;
5. Employment; or
6. Satisfaction of any combination of the above factors.

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

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

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

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

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

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

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

3. The Technology must improve the net health outcome;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Preferred Provider means any Health Care Provider that is not a Preferred Provider.

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

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

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

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a Health Care Provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B”.

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

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

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

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

Preferred Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members. The contracted Preferred Provider has the obligation of referring Members within the network. Preferred Provider relates only to method of payment, and does not imply that any Health Care Provider is more or less qualified than another.

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

Prescription Drug means: (i) a drug, biological or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;" (ii) drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst; (iii) an Over-the-Counter medication or supply included on the Preferred Preventive Drug List; and (iv) any Diabetic Supply.

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

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

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

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

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

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

<table>
<tr><th>Home Health Care</th><th>Outpatient
Private Duty Nursing Rider</th><th>Inpatient hospital/facility
Skilled Nursing Facility</th></tr>
<tr><td colspan="2">Medically Necessary skilled care services performed in the home, by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).</td><td rowspan="4">Skilled Nursing Care rendered on an inpatient basis, means care for medically fragile Members with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the Member's safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week.</td></tr>
<tr><td colspan="2">Skilled Nursing Care visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if visits were not provided, a Member would have to be admitted to a hospital or Skilled Nursing Facility).</td></tr>
<tr><td>Skilled Nursing Care services must be based on a Plan of Treatment submitted by a Health Care Provider.</td><td rowspan="2">Skilled Nursing Care must be ordered by a physician, and based on a Plan of Treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.</td></tr>
<tr><td>Services of a home health aide, medical social worker or registered dietician may also be provided but must be performed under the supervision of a licensed professional (RN or LPN) nurse.</td></tr>
<tr><td colspan="3">Skilled Nursing Care is not Medically Necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the Activities of Daily Living (ADL), including, but not limited to, bathing, feeding, and toileting is not Skilled Nursing Care.</td></tr>
</table>

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

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

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

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

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

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

> NOTE**:** If both the Subscriber and Dependent spouse qualify as "Subscribers" of the Group they may not enroll under separate Individual Type of Coverage memberships; i.e., as separate "Subscribers."

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

ELIGIBILITY AND ENROLLMENT

2.1 **Requirements for Coverage**

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

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

A. The individual elects coverage;

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

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

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

2.2 **Enrollment Opportunities and Effective Dates**

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

A. **Open Enrollment Period**

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

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

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

B. **Newly Eligible Subscriber**

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

C. **Special Enrollment Periods**

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

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

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

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

a. Special enrollment for certain individuals who lose coverage:

1) CareFirst will permit current employees and dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.

2) Individuals eligible for special enrollment.

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

A) The employee and the dependents are otherwise eligible to enroll;

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

C) The employee satisfies the conditions of paragraph a.3)i), ii), or iii) of this section, and if applicable, paragraph a.3)iv) of this section.

ii) When dependent loses coverage.

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

1) The dependent and the employee are otherwise eligible to enroll;
2) When coverage was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and
3) The dependent satisfies the conditions of paragraph a.3)i), ii), or iii) of this section, and if applicable, paragraph a.3)iv) of this section.

B) However, CareFirst is not required to enroll any other dependent unless the dependent satisfies the criteria of this paragraph a.2)ii), or the employee satisfies the criteria of paragraph a.2)i) of this section.

3) Conditions for special enrollment.

i) Loss of eligibility for coverage. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph 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 employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:

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

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

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

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

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

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

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

b. Special enrollment with respect to certain dependent beneficiaries:

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

If the employee is already enrolled under a Family Type of Coverage, a newly born 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. First Eligibility Date is defined as: for a newly born child, the child's date of birth; for a newly 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; for a grandchild for whom the employee has been granted legal custody, the date of the court decree or the date the court decree becomes effective, whichever is later; for a minor for whom guardianship has been granted by court or testamentary appointment, the date of the appointment. Where the addition of a child does not change the Subscriber's Type of Coverage, CareFirst does not require notification within the first 31 days for coverage to continue beyond the 31-day period; however, CareFirst will not be able to properly process claims for the child until notice is given.

2) 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 b.2)i), ii), iii), iv), v), or vi) of this section.

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

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

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

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

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

A) The employee and the spouse become married; or

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

iv) 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.

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

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

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

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

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

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

MEDICAL CHILD SUPPORT ORDERS

3.1 **Definitions**

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

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

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

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

3.2 **Eligibility and Termination**

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

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

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

1. Was born out of wedlock.

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

3. Does not reside with the Subscriber.

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

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

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

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

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

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

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

3.3 **Administration**

When the child subject to an MCSO/QMSO does not reside with the Subscriber, CareFirst will:

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

B. Allow the non-insuring custodial parent or a Health Care Provider of a Covered Service to submit a claim without the approval of the Subscriber;

C. Provide benefits directly to:

1. The non-insuring parent;

2. The Health Care Provider of the Covered Services; or

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

TERMINATION OF COVERAGE

4.1 Disenrollment of Individual Members

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

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

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

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

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

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

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

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

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

4.2 Death of a Subscriber

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

4.3 Effect of Termination

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

4.4 Reinstatement

Coverage will not reinstate automatically under any circumstances.

CONTINUATION OF COVERAGE

5.1 **Continuation of Eligibility upon Loss of Group Coverage**

A. **Federal Continuation of Coverage under COBRA**

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

B. **Uniformed Services Employment and Reemployment Rights Act** (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services.

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

5.2 **Extension of Benefits for Inpatient or Totally Disabled Individuals**

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

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

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

2. 12 months after the date coverage terminates.

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

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

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

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

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

2. 12 months after the date coverage terminates.

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

C. This section does not apply if:

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

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

COORDINATION OF BENEFITS (COB); SUBROGATION

6.1 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 Determination Rules should be looked at first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:

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

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

B. Definitions

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

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

CareFirst Plan means this Evidence of Coverage.

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

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

The term Plan does not include:

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

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

3. Coverage regulated by a motor vehicle reparation law;

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

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

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

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

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

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

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

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

C. **Order of Benefit Determination Rules.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Insurance companies; or

3. Other organizations.

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

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

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

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

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

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

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

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

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

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

HOW THE PLAN WORKS

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

Appropriate Care and Medical Necessity

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

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

Choosing a Provider

Member/Health Care Provider Relationship

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

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

Contracted Health Care Providers

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

2. CareFirst will pay benefits directly to the Contracted Health Care Provider.

3. The Member is responsible for any applicable Deductible and Coinsurance or Copayment.

Preferred Providers

If a Member chooses a Preferred Provider, the cost to the Member is lower than if the Member chooses a Non-Preferred Provider. Throughout the Schedule of Benefits, payments are listed as either “in-network” (for a Preferred Provider) or “out-of-network” (for a Non-Preferred Provider).

Non-Contracted Health Care Provider

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

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

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

4. The Member is responsible for the difference between CareFirst’s payment and the Non-Contracted Health Care Provider’s charge.

If a Preferred Provider refers a Member to a Non-Preferred Provider, CareFirst will pay the in-network benefit, but the Member will still be responsible for the difference between CareFirst’s payment and the Non-Preferred Provider’s charge.

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

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

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

Claims for medical benefits must be submitted by the end of the year following the year during which the services were rendered.

Claims for Prescription Drug Benefits must be submitted by the end of the year following the year during which the services were rendered.

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

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

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

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

Assignment of Benefits
A Member may not assign his or her right to receive benefits or benefit payments under this Evidence of Coverage to another person or entity except for routine assignment of benefit payments to a Preferred Provider /Contracting Pharmacy rendering Covered Services.

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

Notices
Notices to Members required under the Evidence of Coverage shall be in writing directed to the Subscriber's last known address. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst of an address change.

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

REFERRALS

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

Referral to a Specialist or Nonphysician Specialist

Nonphysician Specialist means a Heath Care Provider who is not a physician who 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 is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.

A Member may request a referral to a Specialist or Nonphysician Specialist who is a Non-Preferred Provider if the Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and

1. CareFirst does not contract with a specialist or Nonphysician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or

2. CareFirst cannot provide reasonable access to a contracted specialist or Nonphysician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

For purposes of calculating any Member payment, CareFirst will treat the services provided by the specialist or Nonphysician Specialist as if the services were provided by a Preferred Provider.

Quick Reference

If a Member sees a	With referral	Without referral	Member liable up to charge (balance billing permitted)
Preferred Provider	In-network benefits will be provided	In-network benefits will be provided	No: Member liable up to the Allowed Benefit
Non-Preferred Provider	In-network benefits will be provided	Out-of-network benefits will be provided	Yes: in-network and out-of-network

INTER-PLAN ARRANGEMENTS DISCLOSURE

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

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

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

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

A. Definitions

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

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

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

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

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

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

B. Negotiated National Account Arrangements

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

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

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

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

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

C. BlueCard® Program

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

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

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

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

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

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

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

D. Non-Participating Providers Outside the CareFirst Service Area

Member Liability Calculation

1. In General

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

2. Exceptions

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

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

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

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

INTER-PLAN PROGRAMS ANCILLARY SERVICES

A. Definitions

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

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

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

B. Member Payment

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

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

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

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

C. Determining the Local Plan

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

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

BENEFITS FOR MEMBERS ENTITLED TO MEDICARE (Medicare Complementary)

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

CareFirst pays only for Covered Services. The Member pays for services, supplies or care which are not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment. The Medicare Part A and Part B deductible and coinsurance is not the same as the Deductible or Coinsurance, defined in Definitions, which may be applied by CareFirst to Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

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

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

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

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

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

DESCRIPTION OF COVERED SERVICES

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

PREVENTIVE AND WELLNESS SERVICES

Benefits are available for:

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

If a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, CareFirst will use reasonable medical management techniques to determine any coverage limitations for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.

CareFirst shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

CLINICAL TRIAL PATIENT COST COVERAGE

A. Definitions

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

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

NIH means the National Institutes of Health.

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

B. Covered Services

1. Benefits for Patient Cost to a Member in a clinical trial will be provided if the Member's participation in the clinical trial is the result of:

   a. Treatment provided for a life-threatening condition; or
   b. Prevention, early detection, and treatment studies on cancer.

2. Coverage for Patient Cost will be provided only if:

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

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

   c. The treatment is being provided in a clinical trial approved by one of the National Institutes of Health; or an NIH Cooperative Group or an NIH Center; or the FDA in the form of an Investigational new drug application; or the federal Department of Veterans Affairs; or an institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office Of Protection From Research Risks of the NIH;

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

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

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

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

DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT TRAINING

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

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

EMERGENCY SERVICES

1. With respect to an Emergency Medical Condition, Emergency Services evaluation, examination, and treatment to stabilize the Member.

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

GENERAL ANESTHESIA FOR DENTAL CARE

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

1. If the Member is:

    a. Seven years of age or younger, or developmentally disabled;

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

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

2. Or, if the Member is:

    a. Seventeen 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 severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.

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

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

    a. A fully accredited specialist in pediatric dentistry;

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

    c. A dentist who has been granted hospital privileges.

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

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

HOME HEALTH CARE

A. Definitions

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

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

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

Home Health Care Visits:

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

2. Up to four hours of Home Health Care service is considered one Home Health Care Visit.

B. Limitations

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

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

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

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

Home Visits Following Childbirth

Home visits following childbirth, including any services required by the attending Health Care Provider:

1. For a Member and Dependent child(ren) who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or 96 hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the attending Health Care Provider;

2. For a Member who, in consultation with her attending Health Care Provider, requests a shorter hospital stay (less than 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated cesarean section):

    a. One home visit following childbirth scheduled to occur within 24 hours after discharge;

    b. An additional home visit following childbirth if prescribed by the attending Health Care Provider.

An attending Health Care Provider may be an obstetrician, pediatrician, other physician, certified nurse-midwife, or pediatric nurse Health Care Provider, attending the Member or newborn Dependent child(ren).

Home visits following childbirth must be rendered:

1. In accordance with generally accepted standards of nursing practice for home-care of a mother and newborn children;

2. By a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health.

Home Visits Following the 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:

1. One home visit following the surgical removal of a testicle scheduled to occur within 24 hours after discharge; and

2. An additional home visit following the surgical removal of a testicle if prescribed by the attending physician.

HOSPICE CARE

A. Definitions

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

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

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

B. Covered Services

Hospice care benefits are available for a terminally ill Member (medical prognosis by a physician that the Member's life expectancy is six months or less).

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

Additionally, hospice care benefits are available for a Member's family (family is the spouse, parents, siblings, grandparents, child(ren), and or Caregiver) for periodic family counseling before the Member's death, and bereavement counseling.

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.

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

1. Inpatient/outpatient medical care and consultations.

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

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

3. Surgery, including oral surgery, limited to:

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

   b. 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.

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

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

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

4. Surgical assistant if the surgery requires surgical assistance as determined by CareFirst.

5. Anesthesia services by a Health Care Provider other than the operating surgeon.

6. Chemotherapy, Infusion Therapy, radiation therapy, renal dialysis.

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

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

9. Acupuncture.

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

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

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

13. Elective sterilization.

14. Skilled Nursing Facility services.

15. 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.

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

17. Family planning services, including contraceptive counseling.

MASTECTOMY-RELATED SERVICES

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

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

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

4. Inpatient hospital services for a minimum of 48 hours following a mastectomy as a result of breast cancer. A Member may request a shorter length of stay if the Member decides, in consultation with the attending physician, that less time is needed for recovery.

    a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, benefits will be provided for:

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

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

    b. For a Member who remains in the hospital for at least forty-eight (48) hours following a mastectomy, coverage will be provided for a home visit if prescribed by the Member's attending physician.

MATERNITY SERVICES AND NEWBORN CARE

1. Health Care Provider services including:

   a. Preventive Prenatal Services. Preventive prenatal services are provided for all female Members including:

      (1) Outpatient obstetrical care of an uncomplicated pregnancy, including pre-natal evaluation and management office visits, one post-partum office visit, and breastfeeding support supplies and consultation; and

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

   b. Outpatient obstetrical care and professional services for all prenatal, delivery and post-partum complications, including, but not limited to, prenatal and post-partum office visits not identified in Section 1.a) above and Ancillary Services provided during those visits. Benefits include Medically Necessary laboratory diagnostic tests and services not identified in Section 1.b) above including, but not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis;

   c. Professional services rendered during a covered hospitalization for an uncomplicated delivery of the child(ren) or for pregnancy-related complications or complications during delivery, including delivery via caesarian section, if the Member delivers during that episode of care, and all Ancillary Services provided during such an event;

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

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

   f. Circumcision.

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

   a. A minimum of:

      1) 48 hours following an uncomplicated vaginal delivery;

      2) 96 hours following an uncomplicated cesarean section.

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

3. Elective abortions.

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

5. Benefits are available for comprehensive lactation support and counseling, by a Health Care Provider during the pregnancy and/or in the post-partum period, and breastfeeding supplies and equipment.

MEDICAL DEVICES AND SUPPLIES

A. Definitions

Durable Medical Equipment means equipment which:

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

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

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

Medical Supplies means items that:

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

Orthotic Device means orthoses and braces which:

1. Are primarily and customarily used to serve a therapeutic medical purpose;
2. Are prescribed by a Health Care Provider;
3. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;
4. May be purely passive support or may make use of spring devices;
5. Include devices necessary for post-operative healing.

Prosthetic Device means a device which:

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

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

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

4. Is prescribed by a Health Care Provider; and

5. Is removable and attached externally to the body.

B. Covered Services

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

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

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

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

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.

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.

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

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.

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

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

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

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

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

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

ORGAN AND TISSUE TRANSPLANTS

A. Definitions

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

B. Written notice

At least 30 days before the start of a planned organ/tissue transplant the recipient's physician must give CareFirst written notice, including proof of Medical Necessity, diagnosis, type of surgery, and prescribed treatment.

C. Recipient/donor benefits

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

D. Covered Services

1. Human organ and tissue transplants: kidney, cornea, bone marrow, liver, heart, pancreas, single/double-lung, heart-lung and Related Services;

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

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

4. Organ transplant procurement benefits for the recipient:

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

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

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

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

E. The organ transplant hospital must:

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

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

3. Be approved by CareFirst.

PATIENT-CENTERED MEDICAL HOME

A. Definitions

Care Coordination Team means the Health Care Providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan means the plan directed by a Health Care Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

Health Care Provider, for purposes of the Patient-Centered Medical Home Program, means a physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services described in this section.

Patient-Centered Medical Home (PCMH) Program means medical and associated services directed by the PCMH team of medical professionals to:

1. Foster the Health Care Provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;

2. Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and

3. Exchange medical information with CareFirst, other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.

Qualifying Individual means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the Patient-Centered Medical Home Program.

Specialist, for purposes of the Patient-Centered Medical Home Program, means a licensed health care provider who is certified or trained in a specified field of medicine.

B. Covered Services

Associated costs for coordination of care for the Qualifying Individual's medical conditions, including:

1. Liaison services between the Qualifying Individual and the Health Care Provider(s), nurse coordinator, and the Care Coordination Team.

2. Creation and supervision of the Care Plan, inclusive of an assessment of the Qualifying Individual's medical needs.

3. Education of the Qualifying Individual/family regarding the Qualifying Individual's disease, treatment compliance and self-care techniques;

4. Assistance with coordination of care, including arranging consultations with Specialists, and obtaining other Medically Necessary supplies and services, including community resources.

C. Limitations

Benefits provided through the Patient-Centered Medical Home Program are available only when provided by a CareFirst-approved Health Care Provider who has elected to participate in the CareFirst Patient-Centered Medical Home Program.

PRESCRIPTION DRUGS

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

Pharmacy-dispensed Prescription Drugs	Prescription Drugs dispensed in the office of a Health Care Provider
Benefits for Pharmacy-dispensed Prescription Drugs, intended for outpatient use, are stated in the Prescription Drug Benefits Rider. Benefits, if available, for Pharmacy-dispensed Prescription Drug contraceptives and contraceptive devices, are stated in the Prescription Drug Benefits Rider.	**Contraceptives**: Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.

REHABILITATIVE AND HABILITATIVE SERVICES

Inpatient Rehabilitative Services
Benefits are available for inpatient Rehabilitative Services.

Outpatient Rehabilitative Services
Benefits are available for the following outpatient Rehabilitative Services: Occupational Therapy, Physical Therapy, Speech Therapy.

Habilitative Services (Dependent child under the age of 19)
Benefits are available for Occupational Therapy, Physical Therapy and Speech Therapy for the treatment of a Dependent child under the age of 19 years with a congenital or genetic birth defect to enhance the Dependent child's ability to function. This includes a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defects include, but are not limited to: autism or an autism spectrum disorder, cerebral palsy, intellectual disability, Down syndrome, spina bifida, hydroencephalocele, and congenital or genetic developmental disability.

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

Benefits will not be provided for maintenance programs.

SURGICAL TREATMENT OF MORBID OBESITY

A. Definitions

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

Morbid Obesity means:

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

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

B. Covered Services

Benefits are provided 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 consistent with guidelines approved by the National Institutes of Health and deemed Medically Necessary by CareFirst.

UTILIZATION MANAGEMENT REQUIREMENTS

Outpatient Pre-Authorization Program
Plan of Treatment

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

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

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

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

4. The Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by the Health Care Provider.

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

   a. Home Health Care
   If the Plan of Treatment is not submitted, benefits will be denied.

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

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

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

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

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

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

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

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

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

   e. Private Duty Nursing
   If the Plan of Treatment is not submitted, benefits will be denied.

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

Hospital PreCertification & Review

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

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

3. Procedures which are normally performed on an outpatient basis will not be approved to be performed on an inpatient basis, unless unusual medical conditions are found through Hospital PreCertification & Review.

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

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

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

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

8. Hospital PreCertification & Review is not applicable to maternity admissions.

<u>Non-Emergency (Elective) Admissions</u>

1. The Member must provide any written information requested by the reviewer for Hospital PreCertification & Review of the admission at least 24 hours prior to the admission.

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

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

<u>Emergency (Non-Elective) Admissions</u>

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

   The reviewer may not render an Adverse Decision or deny coverage for Medically Necessary Covered Services solely because the hospital did not notify the reviewer of the emergency admission within 24 hours if the Member's medical condition prevented the hospital from determining:

   a. The Member's insurance status; and

   b. The reviewer's emergency admission notification requirements.

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

   a. During the first 24 hours the Member is in an inpatient facility; or

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

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

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

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

   a. A Member will have to pay:

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

      2) Non-Preferred Providers if a non-elective admission results in payment denial.

   b. A Member will not have to pay Preferred Providers:

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

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

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

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

Program Monitoring
1. The Member's medical record will be reviewed by the reviewer.

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

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

   a. Verify that the services are covered under the Evidence of Coverage;

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

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

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

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

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

Complex Case Management
This is a feature of this health benefit plan for a Member with a chronic condition, a serious illness, or complex health care needs. Specialty Case Managers will initiate and perform CCM services, as deemed Medically Necessary by the Member's treating physician or nurse practitioner and CareFirst. Benefits include:

1. Assessment of Qualified Individual/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;

2. Education of Qualified Individual/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;

3. Assistance in navigating and coordinating health care services and understanding benefits;

4. Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Individual's care with Specialty Case Managers;

5. Assistance in arranging consultation(s) with physician Specialists;

6. Locating community resources, and other organizations/support services to supplement the Care Plan; and

7. Implementation of a Care Plan in consultation with the Qualified Individual's treating physician or nurse practitioner.

Second Surgical Opinion
A Member may seek a second opinion before undergoing any elective surgery, to assure that the surgery is necessary, and to learn of any alternative treatments. A Member may seek a second opinion when required by a hospital's utilization review program.

EXCLUSIONS

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

CareFirst will not provide a benefit for:

- Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.

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

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

  This exclusion does not apply to:

  1. Medicaid;

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

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

- Services that are not specifically shown in this Evidence of Coverage as a Covered Service or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a Preferred Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.

- Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

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

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

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

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

- All Over-the-Counter items and supplies, routinely obtained and self-administered by the Member including, but not limited to: non-prescription eye wear; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and Over-the-Counter solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

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

- Lifestyle improvements, including, but not limited to health education classes and self-help programs except as stated in the Description of Covered Services.

- Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment.

- Treatment for weight reduction and obesity except for the surgical treatment of Morbid Obesity. These exclusions do not apply to the treatment of childhood obesity under a Patient-Centered Medical Home Program Care Plan.

- Routine eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.

- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.

- Services furnished as a result of a referral prohibited by law.

- Any recreational activity intended as a rehabilitative service. This includes, but is not limited to: sports, games, horseback riding , and athletic training, even though such services may have therapeutic value or be provided by a Health Care Provider.

- Non-medical Health Care Provider services, including, but not limited to:

    1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.

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

- Educational therapies intended to improve academic performance.

- Vocational rehabilitation and employment counseling.

- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services) except General Anesthesia & Associated Hospital or Ambulatory Surgical Facility Services for Dental Care.

- Separate billings for health care services or supplies furnished by an employee of a Health Care Provider which are normally included in the Health Care Provider's charges and billed for by them.

- Services that are non-medical in nature, including, but not limited to personal hygiene, Cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.

- Personal comfort items, even when used by a member in an inpatient hospital setting, such as telephones, televisions, guest trays, or laundry charges.

- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living; e.g., bathing, toileting, and eating (care which may be provided by persons without professional medical skills or training).

- Self-care or self-help training designed to enable a member to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated.

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

- Dietary or nutritional counseling except as stated in the Description of Covered Services.

- Tinnitus maskers, purchase, examination, or fitting of Hearing Aids except as stated in the Description of Covered Services, Medical Devices and Supplies, Hearing Aids. Hearing care benefits for an adult Member may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.

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

CareFirst will not provide a benefit for:

General anesthesia and associated hospital or ambulatory surgical facility services for dental care
- Dental care for which general anesthesia is provided.

Home Health Care
- Rental or purchase of renal dialysis equipment and supplies.

- "Meals-on-Wheels" type food plans.

- Domestic or housekeeping services.

- Care that, after training by skilled personnel, can be rendered by a non-Health Care Provider, such as one of the Member's family or a friend (changing dressings for a wound is an example of such care).

Hospice care
- Any services other than palliative treatment.

- Rental or purchase of renal dialysis equipment and supplies.

- Domestic or housekeeping services.

- "Meals on Wheels" or similar food arrangements.

Infertility services
- When the Member or spouse has undergone elective sterilization with or without reversal.

- When any surrogate or gestational carrier is used.

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

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

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

Inpatient/outpatient Health Care Provider services
- Medical care for inpatient stays that are primarily for any diagnostic service and/or observation.

- Medical care for inpatient stays that are primarily for Rehabilitative Services, except inpatient Comprehensive Physical Rehabilitation Services.

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

- Inpatient Private Duty Nursing.

- Procedures to reverse sterilization.

- Surgical removal of impacted teeth.

Medical Devices and Supplies

- Cranial molding orthoses for positional/deformational/non-synostotic plagiocephaly or brachycephaly.
- Durable Medical Equipment or supplies associated or used in conjunction with non-covered items or services.
- Food and formula consumed as sole source or supplemental nutrition except as stated in the Description of Covered Services.

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

- Marital counseling.
- Wilderness programs.
- Boarding schools.

Organ and tissue transplants

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

Prescription Drugs

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

Rehabilitative and Habilitative Services

- Outpatient Comprehensive Physical Rehabilitation Services.
- Services delivered through early intervention and school services.
- Habilitative Services for a Member 19 years and older.

ELIGIBILITY SCHEDULE

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

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

SPECIAL ENROLLMENT PERIODS	
Special enrollment for certain individuals who lose coverage (not applicable to retirees, if retirees are eligible for coverage)	The employee must notify the Group, and the Group must notify CareFirst no later than 31 days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least 31 days after a claim is denied due to the operation of a lifetime limit on all benefits. A new Subscriber and/or his/her Dependent(s) is effective on the first of the month following acceptance of the enrollment by CareFirst.
Special enrollment for certain dependent beneficiaries	The employee must notify the Group, and the Group must notify CareFirst during the 31-day special enrollment period beginning on the date of the marriage, birth, or adoption or placement for adoption. A new Subscriber and/or his/her Dependents is effective as follows: In the case of marriage: the date of marriage. In the case of a newly born child: the date of birth. In the case of an adopted child: the date of adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.
Special enrollment regarding Medicaid and CHIP termination or eligibility	The employee must notify the Group, and the Group must notify CareFirst no later than 60 days after the date the employee or dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act. The employee must notify the Group, and the Group must notify CareFirst no later than 60 days after the date the employee or dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan). A new Subscriber and/or his/her dependents are effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.

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

SCHEDULE OF BENEFITS

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

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

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

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

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

Covered Service(s); and

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

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

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

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

DEDUCTIBLE: Out-of-Network Only		
Individual	Family	
$200	$400	
Deductible applicable to Out-of-Network Covered Services.		
The Deductible is calculated based on the Allowed Benefit of Covered Services.		
The family Deductible amount is calculated in the aggregate. CareFirst pays benefits for a family Member in a family Type of Coverage who reaches the individual Deductible amount before the family Deductible amount is reached. A family Member may not contribute more than the individual Deductible amount to the family Deductible amount.		
The following amounts are included/excluded from the Deductible:	**Included**	**Excluded**
Amounts in excess of the Allowed Benefit	No	Yes
Copays	No	Yes
Prescription Drug Benefits Rider	No	Yes

COMMON ACCIDENT DEDUCTIBLE
When two or more family Members Incur Covered Services due to the same accident, only one individual Deductible amount will be applied in a Benefit Period.

CARRY-OVER DEDUCTIBLE
Covered Services Incurred in the last 3 months of the Benefit Period which were applied to such Benefit Period's Deductible will be applied to the next Benefit Period's Deductible.

OUT-OF-POCKET MAXIMUM			
In-Network		**Out-of-Network**	
Individual	Family	Individual	Family
$1,000	$2,000	$1,000	$2,000
In-Network and Out-of-Network			
The in-network and out-of-network Out-of-Pocket Maximum will be a combined amount.			
"In-network" Out-of-Pocket Maximum amounts apply when the CareFirst payment for Covered Services rendered or referred by a Non-Preferred Provider is at the "in-network" level.			
Family Out-of-Pocket Maximum Information: The family Out-of-Pocket Maximum is calculated in the aggregate. A family Member may not contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.			
CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Out-of-Pocket Maximum is met. Copays will be waived for the remainder of the Benefit Period.			
The following amounts are included/excluded from the Out-of-Pocket Maximum:	**Included**	**Excluded**	
Amounts in excess of the Allowed Benefit	No	Yes	
Deductible	Yes	No	
Coinsurance (Member's share)	Yes	No	
Copays	Yes	No	
Prescription Drug Benefits Rider	No	Yes	

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

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Infant, child, and adolescent preventive and wellness services (office visit)	100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	
Office	100% of Allowed Benefit	No Deductible required 80% of Allowed Benefit
Adult preventive and wellness services (office visit)	100% of Allowed Benefit	80% of Allowed Benefit
Immunizations (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)	100% of Allowed Benefit	80% of Allowed Benefit
Diagnostic services (regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider)		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	
Office	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Chlamydia screening	**Limitations** Benefits for Chlamydia screening are limited to one screening per Benefit Period.	
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	
Office	100% of Allowed Benefit	80% of Allowed Benefit
Human papillomavirus screening		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	
Office	100% of Allowed Benefit	80% of Allowed Benefit
Colorectal cancer screening (including colonoscopy, flexible sigmoidoscopy)		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	
Office	100% of Allowed Benefit	80% of Allowed Benefit
Mammography/breast cancer screening		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	
Office	100% of Allowed Benefit	80% of Allowed Benefit
Osteoporosis prevention		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	
Office	100% of Allowed Benefit	80% of Allowed Benefit
Prostate cancer screening		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	
Office	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Subsequent treatment of a condition diagnosed during a preventive and wellness services office visit (treatment for which is not included in preventive and wellness services benefits)	Benefits are available to the same extent as benefits provided for other illnesses.	
Primary purpose of the office visit is not the delivery of preventive and wellness services	100% of Allowed Benefit after $15 PCP Copay or $20 Specialist Copay	80% of Allowed Benefit
Office visit and, if not billed separately, preventive and wellness services		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Clinical trials	**Limitations** Hospital PreCertification & Review is required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Diabetes equipment, supplies, and self-management training	Benefits are available to the same extent as benefits provided for Medical Supplies and outpatient medical care.	

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Emergency Services		
Emergency Services in a hospital emergency room/department		
Hospital (medical emergency)	100% of Allowed Benefit after $75 Copay* *****Copay waived if admitted	80% of Allowed Benefit
Other hospital services (accidental injury)	100% of Allowed Benefit after $75 Copay* *Copay waived if admitted	No Deductible required 100% of Allowed Benefit after $75 Copay* *****Copay waived if admitted
Outpatient professional (medical emergency)	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional (accidental injury)	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Member admitted as inpatient	No Deductible required 100% of Allowed Benefit	
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department		
Office (medical emergency)	100% of Allowed Benefit after $15 PCP Copay or $20 Specialist Copay	80% of Allowed Benefit
Office (accidental injury)	100% of Allowed Benefit after $15 PCP Copay or $20 Specialist Copay	No Deductible required 100% of Allowed Benefit after $15 PCP Copay or $20 Specialist Copay
Dental services related to accidental injury or trauma	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit

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

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

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Home Health Care	**Limitations** An approved Plan of Treatment is required for Home Health Care. Hospital/home health agency: 90 days of unlimited Home Health Care Visits. Hospital/home health agency: 40 Home Health Care Visits.	
	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Home visits following childbirth	Home Health Care Visit limits, if applicable, do not apply	
	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Home visits following the surgical removal of a testicle	Home Health Care Visit limits, if applicable, do not apply.	
	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Home visits following mastectomy	Home Health Care Visit limits, if applicable, do not apply.	
	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit

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

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

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient Health Care Provider Services	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient hospital or health care facility	**Limitations** Hospital PreCertification & Review is required	
	100% of Allowed Benefit	80% of Allowed Benefit
Skilled Nursing Facility	**Limitations** Hospital PreCertification & Review is required	
	100% of Allowed Benefit	80% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery	100% of Allowed Benefit	80% of Allowed Benefit
Radiologist, pathologist, anesthesiologist, surgical assistant	100% of Allowed Benefit	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Outpatient hospital illness visits/other hospital services	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Surgery	100% of Allowed Benefit	80% of Allowed Benefit
Ambulatory surgical centers	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Chemotherapy		
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Inhalation therapy		
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Radiation therapy		
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Renal dialysis		
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Diagnostic services		
Laboratory tests and X-Rays		
Hospital	100% of Allowed Benefit after $50 Copay	80% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	
Office	100% of Allowed Benefit after $15 Copay	80% of Allowed Benefit
Other diagnostic services		
Hospital	100% of Allowed Benefit after $50 Copay	80% of Allowed Benefit
Outpatient professional practitioner	No Deductible required 100% of Allowed Benefit	
Office	100% of Allowed Benefit after $30 Copay	80% of Allowed Benefit
Contraceptive exam, insertion and removal	100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient/Outpatient Health Care Provider Services		
Cleft lip or cleft palate, or both		
Orthodontics, oral surgery	100% of Allowed Benefit	80% of Allowed Benefit
Otological, audiological and speech/language treatment	Rehabilitative Services visit limits for Speech Therapy, if applicable, do not apply	
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Female elective sterilization	100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.
Male elective sterilization	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Outpatient health care practitioner		
Medical care and consultations		
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $15 PCP Copay or $20 Specialist Copay	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Outpatient health care practitioner		
Administration of injectable Prescription Drugs	100% of Allowed Benefit	80% of Allowed Benefit
Acupuncture		
	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Allergen immunotherapy (allergy injections) excluding the allergenic extracts (sera)	100% of Allowed Benefit	80% of Allowed Benefit
Allergenic extracts (sera)	100% of Allowed Benefit	80% of Allowed Benefit
Allergy testing	100% of Allowed Benefit	80% of Allowed Benefit
Spinal manipulation		
	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Vision therapy (orthoptics/pleoptics)	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Maternity services and newborn care	Benefits are provided for the following: • Subscriber • spouse • Dependent children.	
Maternity services and newborn care except preventive prenatal services	Benefits are available to the same extent as benefits provided for other illnesses.	
Preventive Prenatal Services	100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.
Lactation support and counseling; Breastfeeding supplies and equipment	100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other outpatient care and medical supplies.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Medical Devices and Supplies		
Durable Medical Equipment	100% of Allowed Benefit	80% of Allowed Benefit
Hair prosthesis	**Limitation** Benefits are limited to one hair prosthesis per Benefit Period.	
	100% of the Allowed Benefit up to $350	
Hearing Aids for a minor Dependent child	**Limitations** Benefits are limited to minor Dependent children	
	100% of the Allowed Benefit every thirty-six (36) months for one Hearing Aid for each hearing-impaired ear	
Non-routine services related to the Hearing Aid dispensing	Benefits are available to the same extent as benefits provided for other illnesses.	
Medical foods and nutritional substances	Benefits are available to the same extent as benefits provided for Medical Supplies	
Medical Supplies	100% of Allowed Benefit	80% of Allowed Benefit
Orthotic Devices, Prosthetic Devices	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Mental health and substance use disorder services, including behavioral health treatment	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient Health Care Provider Services	**Limitations** Hospital PreCertification & Review is required	
	Benefits are available to the same extent as Inpatient Health Care Provider services benefits provided for other illnesses.	
Outpatient Health Care Provider Services (except outpatient methadone maintenance treatment)	Benefits for outpatient care are available, including: • psychological and neuropsychological testing for diagnostic purposes; and • visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy.	
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Outpatient methadone maintenance treatment	**Limitations** Member payment for methadone maintenance will not be greater than 50% of its daily cost.	
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Emergency Services	Benefits are available to the same extent as Emergency Services benefits for other illnesses.	
Prescription Drugs	Benefits are available to the same extent as Prescription Drug benefits for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Organ and tissue transplants		
Kidney, cornea, bone marrow	100% of Allowed Benefit	80% of Allowed Benefit
Liver, Heart, Pancreas, Single/Double-Lung, Heart & Lung	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Organ transplant procurement		
Organ transplant travel	100% of charges limited to 75 days maximum per Organ transplant.	

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Patient-Centered Medical Home Program	100% of Allowed Benefit	No benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Prescription Drugs		
Prescription Drugs	**Limitations** Benefits for Pharmacy-dispensed Prescription Drugs, intended for outpatient use, are stated in the Prescription Drug Benefits Rider; otherwise, benefits for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.	
	Benefits are available to the same extent as benefits provided for other illnesses.**]**	
Prescription Drug contraceptives and contraceptive devices dispensed in the office of a Health Care Provider	100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.

Covered Service	CareFirst Payment	
Professional Nutritional Counseling/Medical Nutrition Therapy	**In-Network**	**Out-of-Network**
	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative and Habilitative Services		
Rehabilitative and Habilitative Services	**Limitations** An approved Plan of Treatment is required for Habilitative Services. 100 combined visit limit per Benefit Period: • Occupational Therapy • Physical Therapy • Speech Therapy.	
Occupational therapy	Visit limit does not apply to Habilitative Services Covered Services.	
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative and Habilitative Services		
Rehabilitative and Habilitative Services	**Limitations** An approved Plan of Treatment is required for Habilitative Services. 100 combined visit limit per Benefit Period: • Occupational Therapy • Physical Therapy • Speech Therapy.	
Physical therapy	Visit limit does not apply to Habilitative Services Covered Services.	
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Speech therapy	Visit limit does not apply to Habilitative Services Covered Services. Visit limit does not apply to otological, audiological and speech/language treatment for cleft lip or cleft palate, or both.	
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Inpatient Physical Rehabilitative Services	**Limitations** Hospital PreCertification & Review is required	
	Benefits are available to the same extent as inpatient benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Surgical treatment of Morbid Obesity	Benefits are available to the same extent as surgical benefits provided for other illnesses.	

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CARDIAC REHABILITATION RIDER

This rider is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. A Member's effective date of coverage under this rider and termination date of coverage under this rider are the same as the Member's effective date and termination date under the Evidence of Coverage.

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

Benefits will not be provided for maintenance programs.

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

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

	CareFirst Payment	
Covered Service	**In-Network**	**Out-of-Network**
Outpatient Cardiac Rehabilitation	**Limitations** Benefits for outpatient Cardiac Rehabilitation are limited to 90 visits per Benefit Period.	
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit	80% of Allowed Benefit

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ADULT HEARING CARE RIDER

This rider is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. A Member's effective date of coverage under this rider and termination date of coverage under this rider are the same as the Member's effective date and termination date under the Evidence of Coverage.

Hearing Aid Allowed Benefit means the dollar amount CareFirst allows for the particular hearing device in effect on the date that the service is rendered.

Benefits are available for:

1. Screening examination to diagnose hearing loss.

2. Medically Necessary audiometric testing by a physician or an audiologist, if the physician who performs the screening exam refers the Member to an audiologist;

3. Non-routine services related to the dispensing of a covered hearing aid, such as assessment, fitting, orientation, conformity and evaluation, within six months of the audiometric testing;

4. Hearing aids if:

    a. The prescription is based upon the most recent audiometric exam and hearing aid evaluation test; and;

    b. The physician or audiologist certifies that the hearing aid provided by the hearing aid specialist conforms to the prescription.

CareFirst's payment for hearing aids is limited to the Hearing Aid Allowed Benefit. Due to the wide variation in hearing aid device technology, the Hearing Aid Allowed Benefit amount does not always cover the full cost of the hearing aid device(s) the Member selects. If the Member selects a hearing aid device(s) where the full cost is not covered by the Hearing Aid Allowed Benefit, the Member will be fully responsible for paying the remaining balance for the hearing aid device(s) up to the provider's charge.

Benefits are not provided for:

1. Hearing aids delivered more than 60 days after the Member's coverage ends under this hearing care benefit;

2. Hearing care after the date a Member's coverage under this Evidence of Coverage terminates.

Adult Hearing Care Rider benefits are not provided for a minor Dependent child (see Description of Covered Services, Medical Devices and Supplies).

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

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

	CareFirst Payment	
Covered Service	**In-Network**	**Out-of-Network**
Hearing care	**Limitations** Benefits are limited to once per 36 months from the first Covered Service.	
Audiometric examination		
Hospital	100% of Allowed Benefit after $35 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Audiometric testing	100% of Allowed Benefit	80% of Allowed Benefit
Non-routine services related to the Hearing Aid dispensing	Benefits are available to the same extent as benefits provided for other illnesses.	
Hearing aids	100% of Allowed Benefit	80% of Allowed Benefit

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OUTPATIENT PRIVATE DUTY NURSING RIDER

This rider is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. A Member's effective date of coverage under this rider and termination date of coverage under this rider are the same as the Member's effective date and termination date under the Evidence of Coverage.

Benefits are available for Medically Necessary Private Duty Nursing, as determined by CareFirst.

Benefits are not provided for Private Duty Nursing rendered in a hospital.

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

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

	CareFirst Payment	
Covered Service	**In-Network**	**Out-of-Network**
Outpatient Private Duty Nursing	**Limitations** An approved Plan of Treatment is required	
	100% of Allowed Benefit	80% of Allowed Benefit

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PRESCRIPTION DRUG BENEFITS RIDER

This rider is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. A Member's effective date of coverage under this rider and termination date of coverage under this rider are the same as the Member's effective date and termination date under the Evidence of Coverage.

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SECTION A DEFINITIONS

In addition to the definitions contained in the Evidence of Coverage, for purposes of Prescription Drug Benefits, the underlined terms, below, when capitalized, have the following meaning:

Allowed Benefit means, for a Prescription Drug Covered Service, the lesser of:

1. The Pharmacy's actual charge; or

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

Contracting Pharmacy: If the Member purchases a Prescription Drug Covered Service 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 Member payment amounts, as stated in the Schedule of Benefits.

Non-Contracting Pharmacy: If the Member purchases a Prescription Drug Covered Service or Diabetic Supply from a Non-Contracting Pharmacy, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst or its designee up to the amount of the Allowed Benefit, minus any applicable Member payment amounts, as stated in the Schedule of Benefits. 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 Pharmacy means the separate independent Pharmacist or Pharmacy that has contracted with CareFirst or its designee to be paid directly for a Prescription Drug Covered Service.

Copayment (Copay) means a fixed dollar amount that a Member must pay for a Prescription Drug/Diabetic Supplies.

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 bioequivalency as a specific Brand Name Drug.

Maintenance Drug means a Prescription Drug anticipated to be required for six months or more to treat a chronic condition. Prescription Drug contraceptives are considered Maintenance Drugs.

Nicotine Replacement Therapy means a product that:

1. Is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and

2. Is approved by the FDA as an aid for the cessation of the use of tobacco products; and

3. Is 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.

Non-Contracting Pharmacy means a Pharmacist or Pharmacy that does not contract with CareFirst or its designee.

Non-Preferred Brand Name Drug means a Brand Name Drug that is not included on the CareFirst Preferred Drug List.

Pharmacist means an individual who practices 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 the CareFirst Preferred Drug List.

Preferred Drug List means the list of Brand Name and Generic Drugs issued by CareFirst and used by Preferred Providers when writing, and Pharmacists when filling, prescriptions. All Generic Drugs are included on the Preferred Drug List. Not all Brand Name Drugs are included on the Preferred Drug List. CareFirst may change this list periodically, without notice to Members, to provide the most cost-effective and comprehensive Prescription Drug benefits to Members. A copy of the Preferred Drug List is available to the Member upon request.

Preferred Preventive Drug means a Prescription Drug including an Over-the-Counter medication or supply dispensed under a written prescription by a Health Care Provider that is included on the CareFirst Preferred Preventive Drug List.

Preferred Preventive Drug List means the Prescription Drugs, including Over-the-Counter medications or supplies, dispensed under a written prescription by a Health Care Provider that are included on the list issued by CareFirst of the items identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B” or as provided in comprehensive guidelines for women’s preventive health supported by the Health Resources and Services Administration. CareFirst may change this list periodically without notice to Members. A copy of the Preferred Preventive Drug List is available to the Member upon request.

Prior Authorization List means the limited list of Prescription Drugs issued by CareFirst for which Preferred Providers when writing, and Pharmacists when filling, must obtain prior authorization. Preferred Providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any drug on the Prior Authorization List. A copy of the Prior Authorization List is available to the Member upon request.

SECTION B DESCRIPTION OF COVERED SERVICES

Benefits are available for:

1. Up to a 34-day supply of a Prescription Drug.
2. Up to a 90-day supply of a Maintenance Drug at a retail Pharmacy.
3. Up to a 100-day supply of allergy sera (serum).
4. Insulin, insulin syringes, and other Diabetic Supplies.
5. Nicotine Replacement Therapy.
6. Prescription Drug vitamins, limited to:
   a. Prenatal vitamins;
   b. Fluoride and fluoride-containing vitamins;
   c. Single entity vitamins, such as Rocaltrol and DHT.
7. Any contraceptive drug or device on the Preferred Preventive Drug List that is obtained under a prescription written by a Health Care Provider.
8. Growth hormones (Prior Authorization List).
9. Self-administered injectable Prescription Drugs and the prescribed syringes.
10. Fertility drugs or agents except for use in connection with Infertility services or treatments covered under the under the medical portion of the Evidence of Coverage.
11. Preferred Preventive Drugs.

SECTION C EXCLUSIONS

Note: these exclusions are in addition to the exclusions in the attached Evidence of Coverage.

Benefits are not provided for:

- Prescription Drugs 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 an inpatient in the health care facility.
- Prescription Drugs for cosmetic use.
- Prescription Drugs for weight loss.
- Prescription Drug vitamins, except as listed herein.
- Injectable Prescription Drugs that require administration by a Health Care Provider, including, but not limited to routine immunizations and boosters. This exclusion does not apply to non-surgical, injectable contraceptives.
- Prescription Drugs administered or dispensed in a Health Care Provider's office except allergy sera (serum).

SECTION E SCHEDULE OF BENEFITS

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

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

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures.

Only Pharmacy-dispensed Prescription Drugs intended for outpatient use are covered, unless otherwise stated.

Unless otherwise stated for a particular Covered Service during a Benefit Period:

Lifetime Maximum
The Lifetime Maximum for all Prescription Drug Covered Services is unlimited per person. This Lifetime Maximum creates no rights to benefits after a Member loses entitlement to coverage or is no longer covered under the Group Contract.

Important note regarding CareFirst/Member Payments
If the cost of the Prescription Drug is less than the Member payment, then the cost of the Prescription Drug will be payable by the Member at the time the prescription is filled.
Member payments are waived for the following:
Preferred Preventive Drugs
Insulin syringes and other Diabetic Supplies
Contraceptive drugs or devices on the Preferred Preventive Drug List that is obtained under a prescription written by a Health Care Provider

Member Copays for a Maintenance Drug shall be applied as shown in the below table:				
	Mail Order (Two Copays)		**Retail (Three Copays)**	
	Up to a 34-day supply	The Member pays one Copay, **plus**	Up to a 34 -day supply	The Member pays one Copay, **plus**
Maintenance Drug	35 through 90-day supply	The Member pays a second Copay for a supply of 35-days or more	35 through 68 -day supply	The Member pays a second Copay for a 35 through 68 -day supply, **plus**
			69 through 90-day supply	The Member pays a third Copay for a supply of 69 days or more

If a Member selects a	When a	The Member will pay the	Plus the difference in cost between the Preferred Brand Name Drug and the Non-Preferred Brand Name Drug
Non-Preferred Brand Name Drug	Preferred Brand Name Drug is available	Non-Preferred Brand Name Drug Copay	No

Covered Service	CareFirst Payment	Member Payment
Generic Drug	100% of Allowed Benefit after Member payment	$5 Copay
Preferred Brand Name Drug		$20 Copay
Non-Preferred Brand Name Drug		$35 Copay
Allergy sera (serum)		The Member pays one Copay

This rider is issued to be attached to the Evidence of Coverage.

CLAIMS PROCEDURES
Internal claims and Appeals and External Review processes

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 as required by 29 CFR 2560.503-1 (the DOL claims procedure regulation), and the Public Health Service Act (PHS Act) requirements with respect to internal claims and Appeals and External Review processes for Group Health Plans that are not grandfathered health plans under §2590.715–1251 as set forth in §2590.715-2719. 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. 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.

A. DEFINITIONS
B. CLAIMS PROCEDURES
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J. NOTICE
K. EXTERNAL REVIEW PROCESS

A. DEFINITIONS

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

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. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Appeal (or Internal Appeal) means review by the Plan or the Plan's Designee of an Adverse Benefit Determination, as required in paragraph E. of this section.

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:

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

2. 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.

Claimant means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the External Review process of paragraph K of this section.

Final External Review Decision, as used in paragraph K. of this section, means a determination by an Independent Review Organization at the conclusion of an External Review.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan or the Plan's Designee at the completion of the Internal Appeals process applicable under paragraph E. of this section (or an Adverse Benefit Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhaustion rules of paragraph E.3 of this section).

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.

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

Independent Review Organization (or IRO) means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to paragraph K. of this section.

NAIC Uniform Model Act means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

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.

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

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

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

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.

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

1. Was relied upon in making the benefit determination;

2. 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;

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

4. 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.

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 and Rescissions 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 five (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 (Internal claims and Appeal process)

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

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

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

      1) Receipt of the specified information, or

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

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

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

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

3) Continued coverage will be provided pending the outcome of an Appeal.

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

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

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

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

3. Deemed exhaustion of internal claims and Appeals processes. If the Plan or the Plan's Designee fails to strictly adhere to all the requirements of this paragraph E. with respect to a claim, the Claimant is deemed to have exhausted the internal claims and Appeals process, except as provided in paragraph two below. Accordingly, the Claimant may initiate an External Review under paragraph K. of this section. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan or the Plan's Designee has failed to provide a reasonable internal claims and Appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

   Notwithstanding paragraph 3 of this section, the internal claims and Appeals process of this paragraph will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan or the Plan's Designee demonstrates that the violation was for good cause or due to matters beyond the control of the Plan or the Plan's Designee and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan or the Plan's Designee and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan or the Plan's Designee. The Claimant may request a written explanation of the violation from the Plan or the Plan's Designee, and the Plan or the Plan's Designee must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and Appeals process of this paragraph to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under paragraph 3 of this section on the basis that the Plan or the Plan's Designee met the standards for the exception under this paragraph, the Claimant has the right to resubmit and pursue the internal Appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan or the Plan's Designee shall provide the Claimant with Notice of the opportunity to resubmit and pursue the internal Appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such Notice.

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

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

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

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

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

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

e. In the case of an Adverse Benefit Determination:

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

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

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

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

Notice will be provided in accordance with paragraph J., herein.

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

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

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

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

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

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

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

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

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

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

   e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and all necessary information, including the Plan's or the Plan Designee's determination on review, may be transmitted between the Plan or the Plan's Designee and the Claimant by telephone, facsimile, or other available similarly expeditious method.

4. Full and fair review. The Plan or the Plan's Designee shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and Appeals process. Specifically, 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 the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date; and

   b. Before the Plan or the Plan's Designee issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date.

5. Avoiding conflicts of interest. In addition to the requirements of paragraphs B. and G. herein, regarding full and fair review, the Plan or the Plan's Designee shall ensure that all claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

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

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

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

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

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

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

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

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

Notice will be provided in accordance with paragraph J., herein.

J. NOTICE

1. Notice. The Plan or the Plan's Designee shall provide Notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph 2. of this section) in accordance with paragraphs F. and I. herein. Additionally:

   a. The Plan or the Plan's Designee shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

   b. The Plan or the Plan's Designee shall provide to a Claimant, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan or the Plan's Designee shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal Appeal under this paragraph or an External Review under paragraph K of this section.

c. The Plan or the Plan's Designee shall ensure that the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the Plan's or the Plan Designee's standard, if any, that was used in denying the claim. In the case of a Notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.

d. The Plan or the Plan's Designee shall provide a description of available Internal Appeals and External Review processes, including information regarding how to initiate an Appeal.

e. The Plan or the Plan's Designee shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and Appeals and External Review processes.

2. Form and manner of Notice.

a. In general. For purposes of this section, a Group Health Plan is considered to provide Relevant Notices in a culturally and linguistically appropriate manner if the Plan or the Plan's Designee meets all the requirements of paragraph b. of this section with respect to the applicable non-English languages described in paragraph c. of this section.

b. Requirements

1) The Plan or the Plan's Designee shall provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non English language and providing assistance with filing claims and Appeals (including External Review) in any applicable non-English language;

2) The Plan or the Plan's Designee shall provide, upon request, a Notice in any applicable non-English language; and

3) The Plan or the Plan's Designee shall include in the English versions of all Notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan or the Plan's Designee.

c. Applicable non-English language. With respect to an address in any United States county to which a Notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

K. EXTERNAL REVIEW PROCESS

1. When filing a request for an External Review, the Claimant will be required to authorize the release of any medical records of the Claimant that may be required to be reviewed for the purpose of reaching a decision on the External Review.

2. In addition to the State information provided below, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to a Claimant in need of assistance.

   EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

   Maryland Office of the Attorney General
   Health Education and Advocacy Unit
   200 St. Paul Place, 16th Floor
   Baltimore, MD 21202
   (877) 261-8807
   http://www.oag.state.md.us/Consumer/HEAU.htm
   heau@oag.state.md.us

3. Scope

   a. In general. Subject to the suspension provision in paragraph b. of this section and except to the extent provided otherwise by the Secretary in guidance, the External Review process established pursuant to this paragraph K. applies to any Adverse Benefit Determination or Final Internal Adverse Benefit Determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of a Group Health Plan is not eligible for the External Review process under this paragraph K.

   b. Suspension of general rule. Unless or until this suspension is revoked in guidance by the Secretary, with respect to claims for which External Review has not been initiated before September 20, 2011, the External Review process established pursuant to this paragraph K. applies only to:

      1) An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan or the Plan's Designee that involves medical judgment (including, but not limited to, those based on the Plan's or the Plan Designee's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or its determination that a treatment is Experimental/ Investigational), as determined by the External Reviewer; and

      2) A Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).

4. Standard External Review for self-insured group health Plans

This section sets forth procedures for standard External Review for self-insured Group Health Plans. Standard External Review is External Review that is not considered expedited (as described in paragraph 5 of this section).

a. Request for External Review. The Group Health Plan allows a Claimant to file a request for an External Review with the Plan or the Plan's Designee if the request is filed within four months after the date of receipt of a Notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a Notice, then the request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

b. Preliminary review. Within five business days following the date of receipt of the External Review request, the Group Health Plan or the Plan's Designee shall complete a preliminary review of the request to determine whether:

1) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

2) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Group Health Plan (e.g., worker classification or similar determination);

3) The Claimant has exhausted the Plan's Internal Appeal process unless the Claimant is not required to exhaust the Internal Appeals process as described under paragraph E.3; and

4) The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Plan or the Plan's Designee shall issue a Notification in writing to the Claimant. If the request is complete but not eligible for External Review, such Notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such Notification shall describe the information or materials needed to make the request complete and the Plan or the Plan's Designee shall allow a Claimant to perfect the request for External Review within the four-month filing period or within the 48-hour period following the receipt of the Notification, whichever is later.

c. Referral to Independent Review Organization. The Group Health Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, the Plan or the Plan's Designee shall take action against bias and to ensure independence. Accordingly, the Plan or the Plan's Designee shall contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The contract between the Plan or the Plan's designee and an IRO, shall include the following:

1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

2) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This Notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the Notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

3) Within five business days after the date of assignment of the IRO, the Plan or the Plan's Designee shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan or the Plan's Designee to timely provide the documents and information will not delay the conduct of the External Review. If the Plan or the Plan's Designee fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO shall notify the Claimant and the Plan or the Plan's Designee.

4) Upon receipt of any information submitted by the Claimant, the assigned IRO shall within one business day forward the information to the Plan or the Plan's Designee. Upon receipt of any such information, the Plan or the Plan's Designee may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan or the Plan's Designee shall not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan or the Plan's Designee decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan or the Plan's Designee shall provide written Notice of its decision to the Claimant and the assigned IRO. The assigned IRO shall terminate the External Review upon receipt of the Notice from the Plan or the Plan's Designee.

5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process applicable under paragraph E. of this section. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(a) The Claimant's medical records;

(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the Plan or the Plan's Designee, Claimant, or the Claimant's treating provider;

(d) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(f) Any applicable clinical review criteria developed and used by the Plan or the Plan's Designee, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

6) The assigned IRO shall provide written Notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO shall deliver the Notice of final External Review decision to the Claimant and the Plan or the Plan's Designee.

7) The assigned IRO's decision Notice will contain:

(a) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(b) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Group Health Plan or to the Claimant;

(f) A statement that judicial review may be available to the Claimant; and

(g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

8) After a final External Review decision, the IRO shall maintain records of all claims and Notices associated with the External Review process for six years. An IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

d. Reversal of Plan's decision. Upon receipt of a Notice of a final External Review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan or the Plan's Designee shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

5. Expedited External Review for self-insured Group Health Plans

a. Request for expedited External Review. The Group Health Plan shall allow a Claimant to make a request for an expedited External Review with the Plan or the Plan's Designee at the time the Claimant receives:

1) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited Internal Appeal under paragraph E.2.a would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited Internal Appeal;

2) A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

b. Preliminary review. Immediately upon receipt of the request for expedited External Review, the Plan or the Plan's Designee shall determine whether the request meets the reviewability requirements set forth in paragraph K.4.b above for standard External Review. The Plan or the Plan's Designee shall immediately send a Notice that meets the requirements set forth in paragraph K.4.b above for standard External Review to the Claimant of its eligibility determination.

c. Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, the Plan or the Plan's Designee will assign an IRO pursuant to the requirements set forth in paragraph K.4.c above for standard review. The Plan or the Plan's Designee shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process.

d. Notice of final External Review decision. The Plan's or the Plan Designee's contract with the assigned IRO shall require the IRO to provide Notice of the final External Review decision, in accordance with the requirements set forth in paragraph K.4.c above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the Notice is not in writing, within 48 hours after the date of providing that Notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Plan or the Plan's Designee.

6. An External Review decision is binding on the Plan or the Plan's Designee, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Plan or the Plan's Designee from making payment on the claim or otherwise providing benefits at any time, including after a final External Review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan or the Plan's Designee shall provide any benefits (including by making payment on the claim) pursuant to the final External Review decision without delay, regardless of whether the Plan or the Plan's Designee intends to seek judicial review of the External Review decision and unless or until there is a judicial decision otherwise.