CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

INDIVIDUAL ENROLLMENT AGREEMENT FOR A QUALIFIED HEALTH PLAN

This Qualified Health Plan is being offered through the Exchange.

This Agreement, including any duly authorized attachments, notices, amendments and riders, is issued to the Subscriber and contains the principal provisions affecting the Member(s) enrolled under the Agreement and other provisions that explain the duties of CareFirst BlueChoice and those of the Subscriber or Application Filer.

The Subscriber or Application Filer accepts and agrees to the Agreement by making payment of the initial Premium to CareFirst BlueChoice. CareFirst BlueChoice agrees to the Agreement when it is issued to the Subscriber.

CareFirst BlueChoice may, under certain circumstances, discontinue coverage of a Member or terminate this Agreement. See Section 4 of the Agreement for additional information.

Subscriber Name: _____

Subscriber ID Number: _____

Agreement Effective Date: _____

Product: _____

Term: This Agreement will have an initial term from the Agreement Effective Date stated above until December 31st of that year. The Agreement will automatically be renewed from year to year on January 1st of each succeeding year unless terminated by CareFirst BlueChoice or the Subscriber or the Application Filer.

CareFirst BlueChoice, Inc.

THE SUBSCRIBER OR APPLICATION FILER MAY CANCEL THIS AGREEMENT WITHIN TEN (10) DAYS

The Subscriber or Application Filer may cancel this Agreement by notifying CareFirst BlueChoice or the Exchange in writing within ten (10) days of the date he or she received it. CareFirst BlueChoice will cancel the Subscriber's coverage at midnight on the day CareFirst BlueChoice or the Exchange receives the cancellation notice. CareFirst BlueChoice will refund any paid Premiums to the Subscriber or Application Filer for coverage beyond the cancellation date.

SECTION 1
DEFINITIONS

The underlined terms when capitalized are defined as follows:

Abuse-Deterrent Opioid Analgesic Drug Product means a brand name or generic opioid analgesic drug product approved by the U.S. Food and Drug Administration with abuse-deterrent labeling that indicates the drug product is expected to result in a meaningful reduction in abuse.

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

Adult means an individual eighteen (18) years old or older.

Advance Payments of the Premium Tax Credit means payment of the tax credits specified under section 1401 of the Affordable Care Act which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through the Exchange.

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

Agreement means this agreement between CareFirst BlueChoice and the Subscriber and it includes the Individual Enrollment Agreement, Benefit Determination and Appeal and Grievance Procedures, Description of Covered Services, Schedule of Benefits, and any duly authorized notices, amendments, and riders.

Allowed Benefit means:

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

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

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

B. Except as otherwise specified in this definition, the Allowed Benefit for a Covered Service rendered by a Non-Contracting Provider, including a Non-Contracting Trauma Physician for trauma care rendered to a Trauma Patient in a Trauma Center, will be no less than the amount provided under §19-710.1 of the Health-General Article, if applicable.

C. For Emergency Services provided by a Non-Contracting Provider, the Allowed Benefit for a Covered Service will be no less than the amount specified in section 2719A of the Public Health Service Act and the regulations promulgated pursuant thereto.

D. For a Non-Contracting Ambulance Service Provider, the Allowed Benefit for a Covered Service will be the greater of the amount required by §19-710.1 of the Health-General Article, if applicable, or the Allowed Benefit for Contracting Ambulance Service Providers.

E. For a Non-Contracting hospital in the State of Maryland, the Allowed Benefit for a Covered Service is a rate set by the state regulatory agency.

F. For a Non-Contracting Provider that is a United States Department of Defense or United States Department of Veterans Affairs health care provider that provides a Covered Service, the Allowed Benefit for a Covered Service will be no less than the United Stated

Department of Defense or United States Department of Veterans Affairs health care provider's actual charges.

G. The Member is responsible for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits.

Pediatric Dental Allowed Benefit means:

A. For Preferred Dentists, the Pediatric Dental Allowed Benefit payable to a Preferred Dentist for a Covered Dental Service will be the amount agreed upon between the Dental Plan and the Preferred Dentist. The Pediatric Dental Allowed Benefit is accepted by the Preferred Dentist as payment in full, except for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits.

B. For Participating Dentists, the Pediatric Dental Allowed Benefit payable to a Participating Dentist for a Covered Dental Service will be the lesser of (1) the Dentist's actual charge; or (2) the benefit amount, according to the Dental Plan's rate schedule for the Covered Dental Service that applies on the date that the service is rendered. The Pediatric Dental Allowed Benefit is accepted by the Participating Dentist as payment in full, except for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits.

C. For Non-Participating Dentists, the Pediatric Dental Allowed Benefit payable to a Non-Participating Dentist for a Covered Dental Service will be determined in the same manner as the Pediatric Dental Allowed Benefit payable to a Participating Dentist. The cost difference between the Pediatric Dental Allowed Benefit and the Non-Participating Dentist's actual charge is a non-covered service.

Vision Allowed Benefit means:

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

1. The Contracting Vision Provider's actual charge; or

2. The benefit amount, according to the Vision Care Designee's Contracting Vision Provider rate schedule for the Covered Vision Service that applies on the date that the service is rendered.

The Vision Allowed Benefit is made directly to a Contracting Vision Provider and is accepted as payment in full.

B. For a Non-Contracting Vision Provider, the Vision Allowed Benefit for a Covered Vision Service is the lesser of:

1. The Non-Contracting Vision Provider's actual charge; or

2. The benefit amount stated in the Schedule of Benefits.

The cost difference between the Vision Care Designee's payment and the Non-Contracting Vision Provider's actual charge is a non-covered service.

Prescription Drug Allowed Benefit means the lesser of:

A. The Pharmacy's actual charge; or

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

When the Member purchases a covered Prescription Drug from a Contracting Pharmacy Provider, the benefit payment is made directly to the Contracting Pharmacy Provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance as stated in the Schedule of Benefits.

When the Member purchases a covered Prescription Drug from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. Except in cases of Emergency Services or Urgent Care received outside of the Service Area, the difference between the non-Contracting Pharmacy's actual charge and the Prescription Drug Allowed Benefit is a non-covered service. In cases of Emergency Services or Urgent Care received outside of the Service Area, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance. In all other cases, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee for the amount up to the Prescription Drug Allowed Benefit, minus any applicable Deductible, or Copayment or Coinsurance.

Ambulance means any conveyance designed and constructed or modified and equipped to be used, maintained, or operated to transport individuals who are sick, injured, wounded, or otherwise incapacitated.

Ambulance Service Provider means a provider of Ambulance services that:

A. Is owned, operated, or under the jurisdiction of a political subdivision of the State of Maryland or a volunteer fire company or volunteer rescue squad; or

B. Has contracted to provide Ambulance services for a political subdivision of the State of Maryland.

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 and 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.

Annual Open Enrollment Period means the periods during each Calendar Year, as designated by the Exchange or applicable law, during which a Qualified Individual may enroll or change coverage in a Qualified Health Plan through the Exchange. The Annual Open Enrollment Period are the dates set forth in 45 CFR 155.410(e).

Application Filer means the parent, guardian, or other representative who submits an Enrollment Application on behalf of a Qualified Individual for a Child-Only Agreement. By submitting the Enrollment Application for a Child-Only Agreement, the Application Filer agrees to be the party responsible under this Agreement for the payment of Premiums and any other amounts due from the Subscriber and to be the party responsible to provide information requested by CareFirst BlueChoice relating to the Subscriber's enrollment or the provision of benefits to the Subscriber.

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

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

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

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.

Calendar Year means January 1 through December 31 of each year.

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

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

Child-Only Agreement means this Agreement where the Subscriber, at the time of enrollment, is under the age of nineteen (19) and has selected Child-Only Coverage.

Child-Only Coverage means coverage where the Subscriber, at the time of enrollment, is under the age of nineteen (19), will only enroll himself or herself under a Child-Only Agreement, and who will not have the right to enroll any Dependents.

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

Contracting Physician means a Contracting Provider who is a licensed physician who has entered into a contract with CareFirst BlueChoice to provide Covered Services to Members and has been designated by CareFirst BlueChoice as a Contracting Physician.

Contracting Pharmacy Provider means a separate independent Pharmacist or Pharmacy that has contracted with CareFirst BlueChoice or its designee to provide covered Prescription Drugs.

Contracting Provider means any physician, health care professional, health care facility or Contracting Pharmacy Provider that has contracted with CareFirst BlueChoice, Inc. to render Covered Services to Members. A Preferred Dentist who provides Covered Dental Services or a Contracting Vision Provider who provides Covered Vision Services is not a Contracting Provider for the purposes of this definition.

Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are rendered when acting within the scope of such license; and that has contracted with the Vision Care Designee to provide Covered Vision Services.

Controlled Clinical Trial means a treatment that is:

A. Approved by an institutional review board;

B. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and

C. Is approved or funded by;

1. The National Institutes of Health or a Cooperative Group.

2. The Centers for Disease Control and Prevention.

3. The Agency for Health Care Research and Quality.

4. The Centers for Medicare & Medicaid Services.

5. Cooperative group or center of any of the entities described in clauses C.1 through C.4 above or the Department of Defense or the Department of Veterans Affairs.

6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

7. The Department of Veterans Affairs, the Department of Defense or the Department of Energy if that the study or investigation has been reviewed and approved through a system of peer review that has been determined:

   a) To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

   b) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

8. The FDA in the form of an investigational new drug application.

9. 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.

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 benches, items available without a prescription).

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

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

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

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

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

Covered Vision Services means Medically Necessary services or supplies listed in Sections 3 and 4 of the Description of Covered Services.

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

Decertification or Decertified means the termination by the Exchange of the certification and offering of this Qualified Health Plan.
Deductible means the dollar amount of the Allowed Benefits payable during a Benefit Period for Covered Services or Covered Dental Services that must first be incurred by the Member before CareFirst BlueChoice will make payments for Covered Services or Covered Dental Services.

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

Dental Plan means the dental program under which the Covered Dental Services are made available to Members. The Dental Plan is offered in conjunction Group Hospitalization and Medical Services, Inc. (GHMSI) or CareFirst of Maryland, Inc. (CFMI), doing business as CareFirst BlueCross BlueShield (CareFirst). If the Agreement is issued in either Prince Georges County or Montgomery County in the State of Maryland, CareFirst BlueCross BlueShield will mean GHMSI. If the Agreement is issued in any other county other than Prince Georges County or Montgomery County, or the City of Baltimore in the State of Maryland, CareFirst BlueCross BlueShield will mean CFMI. CareFirst contracts with Preferred and Participating Dentists and provides claims processing and administrative services under the Dental Plan.

Dental Specialist means a Dentist who is certified or trained in a specific field of dentistry.

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

Dependent means an eligible Spouse, Domestic Partner, or Dependent Child as defined in Sections 2.2, 2.3, and 2.4.

Dependent Child or Dependent Children means an individual defined in Section 2.4.

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

Domestic Partner means a person who has a Domestic Partnership with the Subscriber.

Domestic Partnership means a relationship between the Subscriber and Domestic Partner that meets the criteria stated in Section 2.3.

Domiciliary Care means services that are provided to aged or disabled individuals in a protective, institutional or home-type environment. Domiciliary Care includes:

A. Shelter;

B. Housekeeping services;

C. Board;

D. Facilities and resources for daily living; and

E. Personal surveillance or direction in the activities of daily living.

Durable Medical Equipment means equipment furnished by a supplier or a home health agency that:

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

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

C. Is ordered or prescribed by a physician or other qualified practitioner;

D. Is consistent with the diagnosis;

E. Is appropriate for use in the home;

F. Is reusable; and

G. Can withstand repeated use.

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

Emergency Medical Condition means the sudden and unexpected onset of a medical condition of sufficient severity, including severe pain, when the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

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

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

C. Serious dysfunction of any of the individual's bodily organs or parts; or

D. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

A. 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

B. Such further medical examination and treatment, to the extent they are within the capability 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)).

Enrollment Application means the information submitted by or on behalf of an individual to the Exchange in connection with a request to enroll under this Agreement as either a Subscriber or Dependent.

Exchange means the Maryland Health Benefits Exchange.

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

Experimental/Investigational means services that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. Experimental/Investigational services do not include Controlled Clinical Trials.

FDA means the United States Food and Drug Administration.

Family Caregiver means a relative by blood, marriage, or Adoption who lives with or is the primary

Caregiver of the terminally ill Member.

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

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

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

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

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

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

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

Home Health Care Visits mean:

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

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

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

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

Institute means the Maryland Institute for Emergency Medical Services Systems.

Limiting Age means the maximum age to which a Dependent Child may be covered. The Limiting Age is the age of twenty-six (26).

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

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

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

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

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

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

Medical Director means a board-certified physician who is appointed by CareFirst BlueChoice. 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 Member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services or supplies are:

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

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

C. Not primarily for the convenience of a Member or health care provider; and

D. Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that Member'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.

Medically Necessary Contact Lenses means contact lenses that are determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism.

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

Member means a Qualified Individual who meets all applicable eligibility requirements, who is enrolled either as a Subscriber or Dependent, and for whom Premiums have been received by CareFirst BlueChoice or the Exchange.

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

Morbid Obesity means a:

A. Body Mass Index that is greater than forty (40) kilograms per meter squared; or

B. Body Mass Index equal to or greater than thirty-five (35) kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

Multiple Project Assurance Contract means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States 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.

Non-Contracting Physician means a licensed doctor who is not contracted with CareFirst BlueChoice to provide Covered Services to Members.

Non-Contracting Provider means any health care provider that has not contracted with CareFirst BlueChoice to provide Covered Services to Members. Neither Participating Dentists or Non-Participating Dentists who provide Covered Dental Services nor Non-Contracting Vision Providers who provide Covered Vision Services are Non-Contracting Providers for the purposes of this definition.

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

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

Non-Physician Specialist means a health care provider who is:

A. Not a physician;

B. 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

C. Certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider.

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

Opioid Analgesic Drug Product means a drug product that contains an opioid agonist and is indicated by the U.S. Food and Drug Administration for the treatment of pain, regardless of whether the drug product:

A. is in immediate release or extended release form; or

B. contains other drug substances.

Out-of-Pocket Maximum means the maximum amount, as defined and calculated in the Schedule of Benefits that the Member will have to pay for his/her share of benefits in any Benefit Period.

Outpatient Rehabilitative Services means occupational therapy, speech therapy and physical therapy provided to Members not admitted to a hospital or related institution.

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

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

Personal Care means a service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation. Personal Care includes:

A. Help in walking;

B. Help in getting in and out of bed;

C. Help in bathing;

D. Help in dressing;

E. Help in feeding; and

F. General supervision and help in daily living.

Pharmacist means an individual licensed to practice pharmacy regardless of the location where the activities of practice are performed.

Pharmacy means an establishment in which prescription or nonprescription drugs or devices are compounded, dispensed, or distributed.

Plan of Treatment means the plan written and given to CareFirst BlueChoice by the attending health care provider on CareFirst BlueChoice forms which shows the Member's diagnoses and needed treatment.

Preferred Brand Name Drug means a Brand Name Drug that is included on CareFirst BlueChoice's Preferred Drug List.

Preferred Dentist means one of a network of Participating Dentists who, at the time of rendering a Covered Dental Service to a Member, has a written agreement with the Dental Plan for the rendering of such service. Preferred Dentist relates only to method of payment, and does not imply that any Dentist is more or less qualified than another. The fact that a Dentist is a Participating Dentist does not guarantee that the Dentist is a Preferred Dentist.

Preferred Drug List means the list of Brand Name Drugs and Generic Drugs issued by CareFirst BlueChoice and used by health care providers when writing, and Pharmacists, when filling, prescriptions. All Generic Drugs are included in the Preferred Drug List. Not all Brand Name Drugs are included in the Preferred Drug List. CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Preferred Drug List is available to the Member upon request.

Premium means the dollar amount the Subscriber or Application Filer remits to CareFirst BlueChoice for health care benefits under this Agreement.

Premium Due Date is the first day of the month for the period for which the Premium applies.

Prescription Drug means

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

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

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

D. Any Diabetic Supply.

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

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

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

CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Preventive Drug List is available to the Member upon request.

Primary Care Physician (PCP) means a Contracting Provider selected by a Member to provide and manage the Member's health care. PCP means health care practitioners in the following disciplines:

A. General internal medicine;

B. Family practice medicine;

C. Obstetrician/Gynecologist;

D. General pediatric medicine; or

E. Geriatric medicine.

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

Professional Nutritional Counseling means individualized advice and guidance given to a Member at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness or condition, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a licensed dietitian-nutritionist, physician, physician assistant or nurse practitioner.

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

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

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

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

B. The Immediate Family or Family Caregivers of those Members.

Qualified Individual means an individual who has been determined by the Exchange to be eligible to enroll.

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

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

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

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

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

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that is accredited or approved under Medicare or The Joint Commission and provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care, or rehabilitation services. Inpatient skilled nursing is for patients who are medically fragile with limited endurance and require a licensed health care professional to provide skilled services in order to ensure the safety of the patient and to achieve the medically desired result. Inpatient skilled nursing services must be provided on a 24 hour basis, 7 days a week.

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

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

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

Specialty Drugs means high-cost injectables, infused, oral or inhaled Prescription Drugs that:

A. Is prescribed for an individual with a complex or chronic medical condition or a rare medical condition, including but not limited to, the following: Hemophilia, Hepatitis C, Multiple Sclerosis, Infertility Treatment Management, Rheumatoid Arthritis, Psoriasis, Crohn's Disease, Cancer (oral medications), and Growth Hormones;

B. Costs $ 600 or more for up to a 30-day supply;

C. Is not typically stocked at retail pharmacies; and,

D. Requires:

1. A difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug; or

2. Enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

E. As used in this definition, the following terms have the meanings described below:

1. Complex or chronic medical condition means a physical, behavioral, or developmental condition that:

a) may have no known cure;

b) is progressive; or

c) can be debilitating or fatal if left untreated or undertreated.

2. Rare medical condition means a disease or condition that affects fewer than:

a) 200,000 individuals in the United States; or

b) approximately 1 in 1,500 individuals worldwide.

Spouse means a Qualified Individual who is legally married to the Subscriber under the laws of the state or jurisdiction in which the marriage was performed.

Step Therapy or Fail-First Protocol means a protocol established by CareFirst BlueChoice that requires a Prescription Drug or sequence of Prescription Drugs to be used by a Member before a Prescription Drug ordered by the Member's provider is covered.

Step Therapy Drug means a Prescription Drug or sequence of Prescription Drugs required to be used under a Step Therapy or Fail-First Protocol.

Subscriber means the Qualified Individual to whom this Agreement has been issued.

Supporting Medical Information, with respect to Step Therapy or Fail-First Protocol, means:

A. A paid claim for a Member from CareFirst BlueChoice or another insurer, nonprofit health service plan or health maintenance organization;

B. A Pharmacy record that documents that a prescription has been filled and delivered to the Member or representative of the Member; or,

C. Other information mutually agreed to by CareFirst BlueChoice and the provider prescribing the Step Therapy Drug.

Trauma Center means a primary Adult resource center Level I Trauma Center, Level II Trauma Center, Level III Trauma Center, or pediatric Trauma Center that has been designated by the Institute to provide care to Trauma Patients. Trauma Center includes an out-of-state pediatric facility that has entered into an agreement with the Institute to provide care to Trauma Patients.

Trauma Patient means a Member that is evaluated or treated in a Trauma Center and is entered into the state trauma registry as a Trauma Patient.

Trauma Physician means a licensed physician who has been credentialed or designated by a Trauma Center to provide care to a Trauma Patient at a Trauma Center.

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

Vision Care Designee means the entity with which CareFirst BlueChoice has contracted to administer Covered Vision Services. CareFirst BlueChoice's Vision Care Designee is Davis Vision, Inc..

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage.

A. The Subscriber must be a Qualified Individual and reside in the State of Maryland.

B. Except for a Dependent Child, a Dependent must be a Qualified Individual and reside in the State of Maryland.

C. An eligible Qualified Individual must timely enroll as provided in Sections 2.6 or 2.7 and CareFirst BlueChoice or the Exchange must receive Premium payments for each enrolled Member.

D. Child-Only Agreement. This Agreement is issued as a Child-Only Agreement where an eligible Qualified Individual or Application Filer submits an Enrollment Application to the Exchange that requests Child-Only Coverage for the Subscriber. The following provisions apply to Child-Only Agreements:

1. The Subscriber must be a Qualified Individual under age nineteen (19) at the time of enrollment under a Child-Only Agreement.

2. Only the Subscriber may enroll in a Child-Only Agreement. Coverage for Dependents is not available and the Subscriber has no right to enroll any Dependent.

3. Sections 2.1B, 2.2, 2.3, 2.4 and the provisions related to the enrollment or termination of Dependents stated in Section 2.6, Section 2.7, and Section 4 are omitted and are inapplicable to a Child-Only Agreement.

2.2 Eligibility of Subscriber's Spouse. The Subscriber may enroll a Qualified Individual that is his or her Spouse as a Dependent. A Subscriber cannot cover a former Spouse once divorced or if the marriage had been annulled. Premium changes resulting from the enrollment of a Spouse will be effective as of the effective date of the Spouse's enrollment.

2.3 Eligibility of Subscriber's Domestic Partner. The Subscriber may enroll a Qualified Individual that is his or her eligible Domestic Partner. A Domestic Partner will be eligible for coverage to the same extent as a Subscriber's Spouse.

A. To be covered as a Domestic Partner of a Subscriber, the Subscriber and the Qualified Individual:

1. Must not be married;

2. Must be in Domestic Partnership or civil union lawfully registered with a state or local government agency authorized to perform such registrations; or

3. Must be in a Domestic Partnership as defined as follows:

a) The Subscriber and the Qualified Individual are the same sex or opposite sex, over the age of eighteen (18) and have the legal capacity to enter into a contract;

b) The Subscriber and the Qualified Individual are not parties to a legally recognized marriage and are not in a civil union or Domestic Partnership with anyone else;

c) The Subscriber and the Qualified Individual are not related to the other

by blood or marriage within four (4) degrees of consanguinity under civil law rule;

d) The Subscriber and the Qualified Individual share a common primary residence. The Subscriber must submit one (1) of the following documents as proof of a shared common primary residence:

(1) Common ownership of the primary residence via joint deed or mortgage agreement;

(2) Common leasehold interest in the primary residence;

(3) Driver's license or State-issued identification listing a common address; or

(4) Utility or other household bill with both the name of the Subscriber and the Domestic Partner appearing.

e) The Subscriber and the Qualified Individual are Financially Interdependent, as defined below, and submit documentary evidence of their committed relationship of mutual interdependence, existing for at least six (6) consecutive months prior to application.

Financially Interdependent means the Subscriber and the Qualified Individual can establish that they are in a committed relationship of mutual interdependence by submitting documentation from any one (1) of the following criteria:

(1) Joint bank account or credit account;

(2) Designation of one partner as the other's primary beneficiary with respect to life insurance or retirement benefits;

(3) Designation of one partner as the primary beneficiary under the other partner's will;

(4) Mutual assignments of valid durable powers of attorney under §13-601 of the Estates and Trusts Article of the Maryland Annotated Code;

(5) Mutual valid written advanced directives under §5-601 of the Health-General Article of the Annotated Code of Maryland, approving the other partner as health care agent;

(6) Joint ownership or holding of investments; or

(7) Joint ownership or lease of a motor vehicle.

B. Premium changes resulting from the enrollment of a Domestic Partner will be effective as of the effective date of the Domestic Partner's enrollment.

2.4 Eligibility of Dependent Children. The Subscriber may enroll a Qualified Individual that is an eligible Dependent Child. Except as otherwise provided, a Qualified Individual who is the child of Domestic Partner is eligible for coverage as any other Dependent Child, if the Domestic Partner and the child of the Domestic Partner meet the qualifications for coverage.

A. Dependent Child means an individual who:

1. Is:

a) The natural child, stepchild, or adopted child of the Subscriber, the Subscriber's Spouse or the Subscriber's Domestic Partner;

b) A child (including a grandchild) placed with the Subscriber, the Subscriber's Spouse or the Subscriber's Domestic Partner for legal Adoption;

c) An individual under testamentary or court appointed guardianship, other than temporary guardianship for less than twelve (12) months duration, of the Subscriber, the Subscriber's Spouse or the Subscriber's Domestic Partner;

d) An individual who is the child dependent of a Domestic Partner is eligible for coverage if the child is a dependent as that term is used in 26 U.S.C. §§ 104, 105 and 106;

e) A child who becomes a Dependent of the Subscriber through a child support order (MCSO) or other court order; or

f) A grandchild of the Subscriber, the Subscriber's Spouse or the Subscriber's Domestic Partner who:

(1) Is unmarried;

(2) Is in the court-ordered custody of the Subscriber, the Subscriber's Spouse or the Subscriber's Domestic Partner;

(3) Resides with the Subscriber, the Subscriber's Spouse or the Subscriber's Domestic Partner; and,

(4) Is a dependent of the Subscriber, the Subscriber's Spouse or eligible Domestic Partner.

2. Is under the Limiting Age of twenty-six (26).

3. Is already the subject of a Medical Child Support Order that creates or recognizes the right of the child to receive benefits under the health insurance coverage of the Subscriber, the Subscriber's covered Spouse or the Subscriber's covered Domestic Partner, that child must be under the Limiting Age stated in item A.2.

B. A child whose relationship to the Subscriber is not listed above, including, but not limited to foster children or children whose only relationship is one of legal guardianship (except as provided above), is not eligible to enroll even though the child may live with the Subscriber and be dependent upon the Subscriber for support.

C. Premium changes resulting from the enrollment of a Dependent Child will be effective as of the Effective Date of the Dependent Child's enrollment.

2.5 Limiting Age for Covered Dependent Children.

A. All covered Dependent Children are eligible up to the Limiting Age of twenty-six (26).

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

1. The Dependent Child is unmarried and is incapable of self-support or maintenance because of mental or physical incapacity;

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

3. The incapacity occurred before the covered Dependent Child reached the Limiting Age; and

4. The Subscriber provides CareFirst BlueChoice with proof of the Dependent Child's mental or physical incapacity within thirty-one (31) days after the Dependent Child reaches the Limiting Age for Dependent Children. CareFirst BlueChoice has the right to verify whether the child is and continues to qualify as an incapacitated Dependent Child.

C. The coverage of a Dependent will terminate as provided in Section 4.2 if a Dependent Child reaches the Limiting Age or if there is a change in their status or relationship of the Dependent to the Subscriber, such that they no longer meet the eligibility requirements of this Agreement.

2.6 Open Enrollment Opportunities and Effective Dates. Qualified Individuals may elect coverage as a Subscriber or Member, as applicable, only during the following times and under the following conditions.

A. Annual Open Enrollment and Effective Date. During an Annual Open Enrollment Period, a Qualified Individual may enroll as a Subscriber or Dependent through the Exchange.

B. Special Enrollment. If a Qualified Individual does not enroll during an Annual Open Enrollment Period, he or she may only enroll through the Exchange during a Special Enrollment Period.

1. A Qualified Individual may enroll as a Subscriber or Dependent upon the occurrence of one of the following qualifying events:

a) The Qualified Individual or a Dependent:

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

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

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

(b) Situations allowing for a Rescission.

(2) Is enrolled in any non-Calendar Year health insurance policy even if the Qualified Individual or his or her Dependent has the option to renew non-Calendar Year health insurance policy. The date of the loss of coverage is the last day of the non-Calendar Year policy year.

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

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

(5) Loses a dependent or is no longer considered a dependent through divorce or legal separation or if the Subscriber or his or her Dependent dies.

b) A Qualified Individual gains, or becomes, a Dependent through marriage, birth, adoption, placement for adoption, grant of court or testamentary guardianship, child support order (MCSO) or other court order, or placement of a child for foster care. The foster child is not eligible for coverage under this Agreement.

c) The Qualified Individual or his or her Dependent was not previously a citizen, national, or lawfully present in the United States and gains such status.

d) The Qualified Individual's or his or her Dependent's enrollment in another Qualified Health Plan or non-enrollment is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, inaction of an officer, employee, or agent of the Exchange or the United States Department of Health and Human Services or its instrumentalities as evaluated and determined by the Exchange.

e) The Qualified Individual is enrolled in an employer-sponsored plan that is not qualifying coverage in an employer-sponsored plan and is allowed to terminate coverage.

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

g) A Qualified Individual or his or her Dependent:

(1) is determined newly eligible or newly ineligible for advance payments of the premium tax credit, or has a change in eligibility for cost-sharing reductions;

(2) who enrolled in the same Qualified Health Plan is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions; or,

(3) who is enrolled in an eligible employer-sponsored plan is determined newly eligible for Advance Payments of the Premium Tax Credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B-

2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.

h) The Qualified Individual or his or her Dependent gains access to new Qualified Health Plans as a result of a permanent move.

i) The Qualified Individual is an Indian, as defined in Section 4 of the Indian Health Care Improvement Act, who may enroll in a Qualified Health Plan or change coverage from one Qualified Health Plan to another one time per month.

j) The Qualified Individual or his or her Dependents demonstrates to the Exchange, in accordance with guidelines issued by the United States Department of Health and Human Services that he or she meets other exceptional circumstances determined by the Exchange.

k) It is determined by the Exchange that a Qualified Individual or his or her Dependent was not enrolled in Qualified Health Plan coverage; was not enrolled in the Qualified Health Plan selected; or is eligible for but not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities.

For the purposes of this provision, misconduct includes, but is not limited to, the failure of the non-Exchange entity to comply with applicable standards, 45 CFR §155, 45 CFR §156, or other applicable Federal or State laws, as determined by the Exchange.

2. With the exception of the qualifying events described in Section 2.6B.1.a), 2.6B.1.g)(3) and 2.6B.1h) above, the Special Enrollment Period for the qualifying events listed above shall be the sixty (60) calendar days after the date of the qualifying event, unless otherwise provided by the Exchange. In the case of a qualifying event under Section 2.6B.1.a), a Qualified Individual or his or her Dependent has sixty (60) calendar days before and after the loss of coverage to select a Qualified Health Plan; in the case of a qualifying event under Section 2.6B.1.g)(3), a Qualified Individual or his or her Dependent has 60 calendar days before and after the loss of eligibility for qualifying coverage in an eligible employer-sponsored plan to select a Qualified Health Plan; and, in the case of qualifying event under 2.6B.1h), a Qualified Individual or his or her Dependent has sixty (60) calendar days before and after the date of a permanent move to select a Qualified Health Plan.

C. Effective Dates.

1. Annual Open Enrollment Effective Dates. The Effective Date for an eligible individual who timely enrolls during an Annual Open Enrollment Period is based on the date during the Annual Open Enrollment Period that the eligible individual enrolled. The Effective Date shall be the date established in 45 CFR §155.410(f), or the date established by the Exchange.

2. The Effective Date for an eligible individual who gains or becomes a Dependent as described in Section 2.6B.1.b) and who enrolls during a Special Enrollment Period is the Dependent Child's First Eligibility Date:

a) First Eligibility Date means

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

(2) For a newly adopted Dependent Child, the earlier of:

(a) A judicial decree of Adoption; or

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

(3) For a Dependent Child for whom guardianship has been granted by court or testamentary appointment or the date of the appointment.

(4) For a child placed for foster care, the date of the placement by the foster care agency or the first of the month following the date of placement by the foster care agency at the Subscriber's option (if approved by the Exchange). The foster child is not eligible for coverage under the Agreement.

(5) For a child subject to a child support order (MCSO or other court order), the date of the child support order.

b) The Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the child's First Eligibility Date. The Subscriber must enroll such a Dependent Child within sixty (60) days of the child's First Eligibility Date when an additional Premium is due for the enrollment of the Dependent Child. Otherwise, the Dependent Child will not be covered beyond thirty-one (31) days and cannot be enrolled until the next Annual Open Enrollment Period. (An additional Premium will be due unless there are three (3) or more Dependent Children under the age of twenty-one (21) already enrolled by the Subscriber.)

3. The Effective Date for a Qualified Individual who gains or becomes a new Dependent through marriage who enrolls during a Special Enrollment Period shall be the first of the month following plan selection.

4. If the Subscriber or his or her Dependent dies as stated in 2.6B.1(a)(5), the Effective Date is the first of the month following plan selection or as determined by the Exchange.

5. The Effective Date for a Qualified Individual or Dependent who loses coverage as described in Section 2.6B.1.a), or 2.6B.1.g)(3) who enrolls during a Special Enrollment Period shall be the first day of the month following loss of coverage if the plan selection is made before or on the day of the loss of coverage. If the plan selection is made after the loss of coverage, the Effective Date of coverage is as described in Section 2.6C.7. The effective date for a Qualified Individual who gains coverage as described in Section 2.6B.1.h) who enrolls during a Special Enrollment Period shall be the first day of the month following the date of the permanent move if the plan selection is made on or before the date of the permanent move. If the plan selection is made after the date of the permanent move, the Effective Date of coverage is as described in Section 2.6C.7.

6. The Effective Date for a Qualified Individual or Dependent who enrolls due to a qualifying event stated in (i) Section 2.6B.1.d) (enrollment or non-enrollment was unintentional, inadvertent, or erroneous and is the result of an error by the Exchange or the United States Department of Health and Human Services), (ii) Section 2.6B.1.f) (a Qualified Health Plan substantially violated a material provision of its contract), (iii) Section 2.6B.1.j) (other exceptional circumstances as determined by the Exchange), or (iv) Section 2.6B.1.k) (misconduct by a non-

Exchange entity as determined by the Exchange) shall be the appropriate date based on the circumstances of the Special Enrollment Period as determined by the Exchange.

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

   a) For enrollment received by the Exchange between the first and the fifteenth (15^{th}) day of the month, the first day of the following month; and

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

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

2.7 Medical Child Support Orders (MCSO).

A. Eligibility and Termination.

1. Upon receipt of an MCSO, CareFirst BlueChoice will accept enrollment of a child that is the subject of an MCSO. Coverage will be effective as of the effective date of the order, and the Premium will be adjusted as needed. If the Subscriber does not enroll the child then CareFirst BlueChoice will accept enrollment from the non-Subscriber custodial parent; or the appropriate child support enforcement agency of any state or the District of Columbia.

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

   a) Was born out of wedlock;

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

   c) Does not reside with the Subscriber; or

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

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

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

   a) The MCSO is no longer in effect; or

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

B. Administration. When a Member subject to an MCSO does not reside with the Subscriber, CareFirst BlueChoice will:

1. Send to the non-insuring custodial parent the identification cards, claims forms, the applicable Agreement and any information needed to obtain benefits;

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

3. Provide benefits directly to:

a) The non-insuring parent;

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

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

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

2.9 Cooperation and Submission of Information. The Subscriber or Application Filer agrees to cooperate with and assist CareFirst BlueChoice and/or the Exchange, including providing CareFirst BlueChoice and the Exchange with reasonable access to eligibility records upon request. At any time that coverage is in effect, CareFirst BlueChoice reserves the right to request documentation substantiating eligibility and to provide any information it receives regarding a Member's eligibility to the Exchange.

Knowingly attempting to obtain, or actually obtaining eligibility for any person known to the Subscriber or Application Filer to be ineligible pursuant to the eligibility provisions stated in this Agreement, shall constitute an act or practice constituting fraud or an intentional misrepresentation of material fact and in addition to the remedies related to Rescission provided in this Agreement, CareFirst BlueChoice reserves to itself any and all rights provided by law for such act or acts.

2.10 If the Exchange has required CareFirst BlueChoice or any of its affiliates to renew the Subscriber's medical benefit plan outside of the Exchange, CareFirst BlueChoice shall terminate the individual medical benefit plan that the Subscriber has outside of the Exchange with CareFirst BlueChoice or any of its affiliates without any further action by the Subscriber the day before the Effective Date of this Agreement if:

A. The Subscriber has applied on the Exchange for an Advanced Premium Tax Credit or Cost-Sharing Reduction;

B. The Exchange has determined that the household is eligible for an Advanced Premium Tax Credit or Cost-Sharing Reduction; and,

C. The Subscriber has paid the Subscriber's portion of the Premium for this Agreement.

For purposes of this provision, Advance Premium Tax Credit means tax credits specified under section 1401 of the Affordable Care Act which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through the Exchange. For purposes of this provision, Cost-Sharing Reduction means an affordability program under Section 1402 of the Affordable Care Act.

If the Exchange does not require CareFirst or any of its affiliates to renew the medical benefit plan outside of the Exchange as referenced above, then this provision will not be applied.

SECTION 3
PREMIUMS AND PAYMENT

3.1. Premiums. The initial Premium is due on or before the Effective Date of this Agreement. Subsequent Premiums are due on the Premium Due Date. The Premium Due Date is the first day of the month for the period for which the Premium applies. The initial Premium is required to effectuate coverage under this Agreement.

Where this Agreement is issued as a Child-Only Agreement, the Subscriber and the Application Filer, by submitting the Enrollment Application to the Exchange, agrees to be the party responsible for the payment of Premiums and any other amounts due under this Agreement.

If the Subscriber or Application Filer elects an electronic payment, CareFirst BlueChoice will not debit or charge the amount of the Premium due prior to the Premium Due Date, except as authorized by the Subscriber or Application Filer.

3.2 Grace Period.

A. Grace Period. Except for the initial Premium and for the Subscribers described in Section 3.2B below, there is a grace period of 31 days beginning on the Premium Due Date within which overdue Premiums can be paid without loss of coverage. The grace period begins on the Premium Due Date. The grace period of 31 days will be granted for the payment of each Premium falling due after the initial Premium. Coverage shall continue in force during the grace period. If Premiums are not received by the Premium Due Date, CareFirst BlueChoice or the Exchange will notify the Subscriber or Application Filer in writing of the overdue Premiums. If CareFirst BlueChoice or the Exchange receives payment of all amounts listed on the notice prior to the end of the grace period, coverage will continue without interruption. If CareFirst BlueChoice or the Exchange does not receive full payment of all amounts listed on the notice prior to the end of this grace period, the Agreement and the enrollment of the Subscriber and any Dependents, shall be terminated as set forth in Section 4.2B.

B. Grace Period for Certain Recipients of Advance Payments of the Premium Tax Credit. If a Subscriber or Member receives Advance Payments of the Premium Tax Credit made to them by the Exchange or to CareFirst BlueChoice on their behalf, there is a grace period of 3 months beginning on the Premium Due Date within which overdue Premiums can be paid without loss of coverage. The grace period begins on the Premium Due Date. If Premiums are not received by the Premium Due Date, CareFirst BlueChoice or the Exchange will notify the Subscriber or Application Filer in writing of the overdue Premiums. This grace period will apply as follows:

1. If CareFirst BlueChoice or the Exchange receives payment of all Premiums due prior to the end of this grace period, coverage will continue without interruption.

2. If CareFirst BlueChoice or the Exchange does not receive payment of all Premiums due prior to the end of this grace period, this Agreement, and the enrollment of the Subscriber and any Dependents, shall be terminated as set forth in Section 4.2B.

3. The grace period provided in Section 3.2A above shall not apply if the Subscriber receives the grace period under this provision.

3.3 Reinstatement.

A. If any Premium is not paid in full within the time granted the Subscriber or Application Filer for payment, a later acceptance of Premium in full by CareFirst BlueChoice or by any agent authorized by CareFirst BlueChoice to accept the Premium, without requiring a reinstatement application in connection with the acceptance of the Premium in full, shall reinstate the Agreement.

B. If CareFirst BlueChoice or the agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Agreement will be reinstated upon approval of the application by CareFirst BlueChoice or, lacking approval, upon the forty-fifth (45^{th}) day following the date of the conditional receipt unless CareFirst BlueChoice has previously notified the Subscriber or Application Filer in writing of its disapproval of the reinstatement application.

C. The Subscriber and CareFirst BlueChoice shall have the same rights under the reinstated Agreement as they had under the Agreement immediately before the due date of the defaulted Premium, subject to any provisions contained within the Agreement in connection with the reinstatement.

D. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

3.4 Premium Adjustments. All Premium adjustments for Members enrolling or terminating during a coverage month will be calculated on a pro-rated basis. Calculated Premium adjustments will be applied to the next month's Premium charges as follows:

A. New enrollment may result in additional Premium charges depending upon the Subscriber's current coverage.

B. All Premium adjustments for Subscribers terminating this Agreement during a coverage month will be calculated on a pro-rated basis. Terminations may result in a credit toward the Premium charges due. If the termination results in an overpayment of Premiums on the Subscriber's part, CareFirst BlueChoice will retroactively adjust the Premium payments but for no more than sixty (60) days retroactively from the date CareFirst BlueChoice or the Exchange received the notice of termination. The Subscriber or Application Filer will be liable for the cost of any benefit provided or paid for services received on or after the effective date of termination. If a refund is available to the Subscriber, CareFirst BlueChoice can subtract these costs from the refund.

C. If termination due to death of a Member resulted in an overpayment of Premiums on the Subscriber's part, CareFirst BlueChoice will retroactively adjust the Premium payments but for no more than sixty (60) days retroactively from the date CareFirst BlueChoice or the Exchange received the notice of the Member's death.

3.5 Premium Rate Changes. There may be a Premium rate change when approved by the Maryland Insurance Administration, as provided by law. CareFirst BlueChoice will not increase the Member's Premium rate more frequently than once every Calendar Year. CareFirst BlueChoice will provide notice of an approved Premium rate change by giving the Subscriber or Application Filer at least forty-five (45) days prior written notice. Any change in Premium rates, including changes in a Member's Premium rate due to a change in a Member's age, will be effective on January 1^{st} of each year this Agreement renews.

Any Premium rate increase justification will be submitted by CareFirst BlueChoice to the Exchange prior to the date of implementation of the increase in accordance with the standards stated 45 CFR §155.1020, as amended. CareFirst BlueChoice will also post notice of the Premium increase and justification for such on the CareFirst BlueChoice website, www.carefirst.com.

CareFirst BlueChoice may change the Premium during a Calendar Year if the change is due solely to the enrollment or termination of a Dependent.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Enrollment by the Subscriber.

A. The Subscriber or Application Filer may terminate his or her enrollment under the Agreement at any time by notifying CareFirst BlueChoice or the Exchange. The Subscriber's enrollment will thereafter be terminated in the manner determined by the Exchange.

1. The Subscriber, Dependents or Application Filer may terminate coverage as a result of the Subscriber or Dependents obtaining other Minimum Essential Coverage.

2. The Exchange will provide an opportunity at the time of plan selection for the Member to remain enrolled in a Qualified Health Plan if he/she becomes eligible for other Minimum Essential Coverage and the Member does not request a termination date in accordance with Section 4.1C. If a Member does not choose to remain covered under this Agreement, the Exchange will initiate termination of the enrollment under this Agreement upon completion of the redetermination process specified in 45 CFR 155.330.

3. The Exchange will allow a Member's authorized representative to report the death of a Member for purposes of initiating termination of the Member's enrollment under this Agreement. The Exchange will determine what supporting documentation must be submitted. CareFirst will determine the Premium adjustment pursuant to Section 3.4 of the Individual Enrollment Agreement.

4. The Exchange will allow a Subscriber, Dependents or Application Filer to retroactively terminate this Agreement if:

a) The Subscriber, Dependents or Application Filer demonstrates to the Exchange that he/she attempted to terminate coverage or enrollment in a Qualified Health Plan and experienced a technical error that did not allow the Subscriber, Dependents or Application Filer to terminate coverage or enrollment through the Exchange, and requests retroactive termination within sixty (60) days after the Subscriber, Dependents or Application Filer discovered the technical error.

b) The Subscriber, Dependents or Application Filer demonstrates to the Exchange that the enrollment in a Qualified Health Plan through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. The Subscriber, Dependents or Application Filer must request cancellation within sixty (60) days of discovering the unintentional, inadvertent, or erroneous enrollment.

For purposes of this provision, misconduct includes the failure to comply with applicable standards under applicable Federal or State requirements as determined by the Exchange.

c) The Subscriber, Dependents or Application Filer demonstrates to the Exchange that he or she was enrolled in a Qualified Health Plan without his or her knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within sixty (60) days of discovering of the enrollment.

B. A Subscriber may terminate the enrollment of a Dependent only in the manner permitted by the Exchange by notifying the Exchange.

C. The effective date of a termination of a Member or this Agreement, when initiated by the Subscriber, will be:

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

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

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

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

5. In the case of retroactive termination under Section 4.1A.4.a), the termination date will be no sooner than fourteen (14) days after the date that the Subscriber, Dependents or Application Filer can demonstrate he or she contacted the Exchange to terminate his or her coverage or enrollment through the Exchange, unless CareFirst BlueChoice agrees to an earlier effective date.

6. In case of a retroactive cancellation or termination in accordance with Sections 4.1A.4.b) or c), the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination.

7. In the case of retroactive cancellations or terminations in accordance with Section 4.1A.4, such terminations or cancellations for the preceding coverage year must be initiated within a timeframe established by the Exchange based on a balance of operational needs and consumer protection. This timeframe will not apply to cases adjudicated through the appeals process.

8. The retroactive termination date requested by the Subscriber if specified and applicable under Maryland law.

4.2 Termination of Agreement by CareFirst BlueChoice or the Exchange. CareFirst BlueChoice or the Exchange may terminate the Agreement or the enrollment of a Dependent under the following circumstances by providing notice of termination, including the termination date and the reason for termination, to the Subscriber or Application Filer at least thirty (30) days prior to the last day of coverage:

A. Termination for ineligibility:

1. The Subscriber is no longer eligible for coverage under this Agreement or is no longer a Qualified Individual eligible to enroll in a Qualified Health Plan through the Exchange. In such a case, the enrollment of the Subscriber and all Dependents will be terminated.

2. A Dependent is no longer eligible for coverage as a Dependent due to a change in the Dependent's age, status or relationship to the Subscriber, or that the Dependent is no longer a Qualified Individual.

3. The Effective Date of Termination Due to Termination for Ineligibility.

   a) When a Dependent is no longer eligible due to reaching the Limiting Age, the effective date of termination will be the end of the Benefit Period in which the Dependent reaches the Limiting Age.

   b) In all other instances, the effective date of termination will be the last day of the month that the Subscriber and/or Dependent is no longer eligible for coverage unless otherwise instructed by the Exchange, except:

      (1) If termination results from redetermination of eligibility for coverage under the Exchange, then the termination date is the first of the month following the date of the notice of determination of eligibility from the Exchange.

      (2) If termination results from an appeal decision, then the termination date is the date specified in the appeal decision.

      (3) If termination is due to the Member obtaining coverage in another Qualified Health Plan, the termination date is the day before the effective date of coverage under the new Qualified Health Plan, including any retroactive enrollments pursuant to 45 CFR 155.420(b)(2)(iii).

      (4) In the case of the death of a Member, the termination date is the date of death.

   c) The Subscriber or Member, as applicable, may request an earlier termination date as provided in Section 4.1.

4. The Subscriber or Application Filer is responsible for notifying the Exchange of any changes in the status of a Member as a Qualified Individual or his or her eligibility for coverage, except when the Dependent Child reaches the Limiting Age. These changes include a death or divorce. If the Subscriber or Application Filer knows of a Member's ineligibility for coverage and intentionally fails to notify the Exchange, CareFirst BlueChoice has the right to seek Rescission of the coverage of the Member or the Agreement under Section 4.3 as of the initial date of the Member's ineligibility. In such a case, CareFirst BlueChoice has the right to recover the full value of the services and benefits provided during the period of the Member's ineligibility. CareFirst BlueChoice can recover these amounts from the Subscriber, the Application Filer, and/or from any terminated Member, at the option of CareFirst BlueChoice, less any Premium paid for the Member's enrollment during the period of ineligibility.

B. Termination of Agreement for Non-Payment of Premiums. In the case of a termination of this Agreement for non-payment of Premiums by the Subscriber or Application Filer, the effective date of termination, after the expiration of the applicable grace period, shall be as follows:

1. Termination of Agreement where the Subscriber does not receive Advance Payments of the Premium Tax Credit. If CareFirst BlueChoice or the Exchange does not receive payment of an overdue Premium prior to the end of the thirty-one (31) day grace period set forth in Section 3.2A, the Agreement, and the enrollment of the Subscriber and any Dependents, will terminate effective as of

the last day of this grace period. The Subscriber or Application Filer will be liable for the full cost of all services or benefits received by any Member on or after the date of termination of this Agreement, except as provided in this Agreement.

2. Termination of Agreement where the Subscriber receives Advance Payments of the Premium Tax Credit. If CareFirst BlueChoice or the Exchange does not receive the overdue Premium by the end of the three (3) month grace period set forth in Section 3.2B, the Agreement, and the enrollment of the Subscriber and any Dependents, shall be terminated as the last day of the first month of the 3-month grace period set forth in Section 3.2B. The Subscriber or Application Filer will be liable for the full cost of all services or benefits received by any Member on or after the date of termination except as provided in this Agreement.

C. Termination due to the Decertification of the Agreement as a Qualified Health Plan. If this Agreement is Decertified as a Qualified Health Plan, the date of termination of this Agreement shall be the date established by the Exchange after written notice has been provided to the Subscriber or Application Filer and the Subscriber has been afforded an opportunity to enroll in other coverage.

D. Additional Causes for Terminations. Termination may be initiated for the following causes:

1. Fraud;

2. Termination or discontinuation of the product in which the Member is enrolled;

3. Except for a Dependent Child, the Member moves outside the CareFirst BlueChoice Service Area, meaning the Member no longer resides, lives, or works inside the Service Area;

4. Discontinuation of all coverage for plans offered by CareFirst BlueChoice in the individual market; and,

5. The Member was enrolled in a Qualified Health Plan without his/her knowledge or consent by a third party, including a third party with no connection with the Exchange.

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

F. In the case of cancellation in accordance with Section 4.2D.5, the Exchange may cancel the Member's enrollment upon its determination that the enrollment was performed without the knowledge or consent of the Subscriber or Application Filer and following reasonable notice to the Subscriber or Application Filer (where possible). The termination date will be the original coverage effective date.

G. If a Member’s coverage is terminated as a result of a determination by the Exchange that the Member is no longer eligible or if the Member’s QHP on the Exchange is Decertified, then the Member may continue coverage offered by CareFirst BlueChoice that is sold off the Exchange if:

1. The Member notifies CareFirst BlueChoice in writing that he/she wishes to do so within 30 days of the Member’s coverage being terminated; and,

2. The Member's coverage was not terminated for non-payment of premium, fraud or an intentional misrepresentation of material fact.

4.3 Rescission of Enrollment for Fraud or Misrepresentation.

A. This Agreement, or the enrollment of a Member, may be Rescinded if:

1. The Member or Application Filer has performed an act, practice, or omission that constitutes fraud; or

2. The Member or Application Filer has made an intentional misrepresentation of material fact.

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

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

4.4 Death of Dependent. In case of the death of a Dependent, the enrollment of the deceased Dependent shall terminate on the date of the Dependent's death.

4.5 Death of Subscriber. In case of the death of the Subscriber;

A. If the Subscriber has enrolled a Spouse or Domestic Partner as a Dependent, the Spouse or Domestic Partner will become the successor Subscriber.

B. If the Subscriber has enrolled one or more Dependent Children (but not a Spouse or Domestic Partner), the Agreement will terminate on the last day of the month of the Subscriber's death.

C. If only the Subscriber is enrolled, the Agreement will terminate on the date of the Subscriber's death.

4.6 Effect of Termination. Except as provided in Sections 4.7, 4.8 and 4.9, no benefits will be provided for any services received on or after the date on which this Agreement terminates. This Section includes services received for an injury or illness that occurred before the effective date of termination.

4.7 Extension of Benefits – Covered Services.

A. If a Member has a claim in progress when his/her coverage terminates, the Member will continue to receive benefits that are related to the claim in accordance with the Agreement in effect at the time the individual's coverage terminates, including benefit maximums, until the earlier of:

1. The date the Member is released from the care of a physician for the condition that is the basis of the claim; or

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

B. During an extension period required under this provision, a Premium may not be charged.

C. This provision does not apply if:

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

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

3. Any coverage provided by a succeeding health benefit plan:

a) Is provided at a cost to the Member that is less than or equal to the cost to the Member of the extended benefit required under this Section.

b) Does not result in an interruption of benefits.

4.8 Extension of Benefits – Covered Dental Services.

A. CareFirst BlueChoice shall provide Covered Dental Services, in accordance with the Agreement in effect at the time the Member's coverage terminates, for a course of treatment for at least ninety (90) days after the date coverage terminates if the treatment:

1. Begins before the date coverage terminates; and

2. Requires two or more visits on separate days to a Dentist's office (this provision does not apply to orthodontic services).

B. CareFirst BlueChoice shall provide benefits for covered orthodontic services, as defined in the attached Description of Covered Services and the attached Schedule of Benefits, for a Member whose coverage terminates:

1. For sixty (60) days after the date the Member's coverage terminates if the orthodontist has agreed to or is receiving monthly payments; or

2. Until the later of sixty (60) days after the date the Member's coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

C. During an extension period required under this provision, a Premium may not be charged.

D. This provision does not apply if:

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

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

3. Any coverage provided by a succeeding health benefit plan:

a) Is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit required under this section; and

b) Does not result in an interruption of benefits.

4.9 Extension of Benefits – Covered Vision Services. If a Member is eligible to receive Covered Vision Services and has ordered frames and spectacle lenses or contact lenses before the date the Member's coverage terminates, the Vision Care Designee will provide benefits for the frames and

spectacle lenses or contact lenses if the Member receives the frames and spectacle lenses or contact lenses within thirty (30) days after the date of the order. During an extension period required under this provision, a Premium may not be charged. This provision does not apply if:

A. Coverage is terminated because an individual fails to pay a required Premium;

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

C. The Member obtained uninterrupted and comparable coverage under a succeeding health care benefit plan that is less than the cost to the Member of the extended benefit.

4.10 Reinstatement. If this Agreement or the enrollment of a Member is canceled, terminated or Rescinded for any reason, enrollment or coverage will not reinstate automatically under any circumstances, unless otherwise provided in this Agreement.

SECTION 5
COORDINATION OF BENEFITS (COB); SUBROGATION

5.1 Coordination of Benefits (COB).

A. Applicability.

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

2. If this COB provision applies, the order of benefit determination rules should be reviewed first. Those rules determine whether the benefits of this CareFirst BlueChoice Plan are determined before or after those of another Plan. The benefits of this CareFirst BlueChoice Plan:

a) Shall not be reduced when, under the order of determination rules, this CareFirst BlueChoice 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 reduction is explained in Section 5.1D.2.

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 Agreement.

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 BlueChoice 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 BlueChoice Plan means this Agreement.

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. Any hospital indemnity or other fixed indemnity coverage contract;

5. An elementary and/or secondary school insurance program sponsored by a school or school system and any school accident-type coverage that covers for accidents only, including athletics injuries.;

6. Medicare supplemental policies;

7. Limited benefit health coverage as defined by state law;

8. Long-term care insurance policies for non-medical services; or

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

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

1. When this CareFirst BlueChoice 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 BlueChoice 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 BlueChoice 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 BlueChoice Plan and another Plan, this CareFirst BlueChoice 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 BlueChoice Plan; and

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

2. Rules. This CareFirst BlueChoice 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 BlueChoice 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 BlueChoice Plan.

1. When this Section Applies. This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst BlueChoice Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst BlueChoice 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 BlueChoice Plan's Benefits. When this CareFirst

BlueChoice Plan is the Secondary Plan, the benefits under this CareFirst BlueChoice 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 BlueChoice Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this CareFirst BlueChoice Plan.

E. Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. CareFirst BlueChoice 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 BlueChoice need not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst BlueChoice Plan must give this CareFirst BlueChoice 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 BlueChoice Plan. If it does, this CareFirst BlueChoice 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 BlueChoice Plan. This CareFirst BlueChoice 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 BlueChoice 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.

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

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

B. Medicare as Primary.

1. When benefits for Covered Services, Covered Dental Services or Covered Vision Services are paid by Medicare as primary, this CareFirst BlueChoice Plan will not duplicate those payments. CareFirst BlueChoice will coordinate and pay benefits based on Medicare's payment (or the payment Medicare would have paid). When CareFirst BlueChoice coordinates the benefits with Medicare, CareFirst BlueChoice's payments will be based on the Medicare allowance (if the provider is a participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare), less any claim reduction or denial due to a Member's failure to comply with Medicare's

administrative requirements. CareFirst BlueChoice's right to coordinate is not contingent on any payment actually being made on the claim by Medicare. Members enrolled in Medicare agree to, and shall, complete and submit to Medicare, CareFirst BlueChoice, and/or any health care providers all claims, consents, releases, assignments and other documents required to obtain or assure such claim payment by Medicare.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G. These provisions do not apply to residents of the Commonwealth of Virginia.

SECTION 6
GENERAL PROVISIONS

6.1 Entire Agreement; Changes. The entire agreement between CareFirst BlueChoice and the Subscriber includes: (a) the Individual Enrollment Agreement; (b) the Benefit Determination and Appeal and Grievance Procedures Attachment; (c) the Description of Covered Services; (d) Schedule of Benefits; and (e) any additional duly authorized notices, amendments and riders.

No amendment or modification of any term or provision of this Agreement shall be valid until approved by an executive officer of CareFirst BlueChoice. Any duly authorized notice, amendment or rider will be issued by CareFirst BlueChoice to be attached to the Agreement. No agent has authority to change this Agreement or to waive any of its provisions. Any waiver of an Agreement term or provision shall only be given effect for its stated purpose and shall not constitute or imply any subsequent waiver.

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

6.2 Claims and Payment of Claims.

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

When a Member subject to a Medical Child Support Order does not reside with the Subscriber, CareFirst BlueChoice will

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

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

3. Provide benefits directly to:

   a) The non-insuring, custodial parent;

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

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

B. Proof of Loss. CareFirst BlueChoice does not require a written notice of claims for services provided by Contracting Providers, Preferred Dentists, Participating Dentists, Contracting Vision Providers or Contracting Pharmacy Providers.

For Covered Services, Covered Dental Services or Covered Vision Services provided by Non-Contracting Providers, Non-Participating Dentists or Non-Contracting Vision Providers, Members must furnish written proof of loss, or have the provider submit proof

of loss, to CareFirst BlueChoice within one (1) year after the date of the loss. Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than two (2) years after the date of service.

A Member's legal incapacity shall suspend the time to submit a claim. This suspension period ends when the Member regains legal capacity.

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

C. Time of Payment of Claims. Except as provided in this paragraph, benefits payable will be paid not more than thirty (30) days after receipt of written proof of loss. Claims for services rendered after expiration of the first month of the grace period for recipients of Advance Payments of the Premium Tax Credit, as set forth in Sections 3.2B. and 4.2B.2., will be pended and will only be paid after the Subscriber makes payment of the Premium due. Any accrued benefits unpaid at the Subscriber's death shall be paid to the Subscriber's estate.

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

E. Payment of Claims – Covered Services. Payments for Covered Services will be made by CareFirst BlueChoice directly to Contracting Providers and Non-Contracting Providers, including Non-Contracting Ambulance Service Providers, and are accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits. The Member is responsible for any applicable Deductible, Copayment and Coinsurance stated in the Schedule of Benefits, and the Contracting Provider or Non-Contracting Provider may bill the Member directly for such amounts. If the Member has paid a Contracting Provider or Non-Contracting Provider for Covered Services rendered, benefits will be payable to the Member.

F. Payment of Claims – Covered Dental Services. Billing and reimbursement will be handled by the Dental Plan for Covered Dental Services. Payments for Covered Dental Services will be made by the Dental Plan directly to Preferred and Participating Dentists and are accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits. The Member is responsible for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits, and the Preferred or Participating Dentist may bill the Member directly for such amounts. If the Member has paid the Preferred or Participating Dentist for Covered Dental Services rendered, benefits will be payable to the Member.

If a Member receives Covered Dental Services from a Non-Participating Dentist, the Dental Plan reserves the right to pay the Pediatric Dental Allowed Benefit either to the Member or to the provider, less any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits. The cost difference between the Pediatric Dental Allowed Benefit and the Non-Participating Dentist's actual charge is a non-covered service. The Non-Participating Dentist may collect from the Member any applicable

Deductible, Copayment or Coinsurance stated in the Schedule of Benefits and for any non-covered service. It is the Member's responsibility to apply any Dental Plan payments received to the claim from the Non-Participating Dentist.

G. Payment of Claims – Covered Vision Services. Billing and reimbursement will be handled by the Vision Care Designee for Covered Vision Services. Payments for Covered Vision Services rendered by Contracting Vision Providers will be paid directly to the Contracting Vision Provider or to the provider's representative by the Vision Care Designee and are accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits. The Member is responsible for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits, and the Contracting Vision Provider may bill the Member directly for such amounts. If the Member has paid the Contracting Vision Provider for Covered Vision Services rendered, benefits will be payable to the Member.

If a Member receives Covered Vision Services from a Non-Contracting Vision Provider, the Vision Care Designee reserves the right to pay the Vision Allowed Benefit either to the Member or to the provider, less any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits. The cost difference between the Vision Care Designee's payment and the Non-Contracting Vision Provider's actual charge is a non-covered service. The Contracting Vision Provider may collect from the Member any applicable Coinsurance, Copayment or any payments for any non-covered services.

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

If the Member purchases a covered Prescription Drug from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. Except in cases of Emergency Services or Urgent Care received outside of the Service Area, the difference between the non-Contracting Pharmacy's actual charge and the Prescription Drug Allowed Benefit is a non-covered service. In cases of Emergency Services or Urgent Care received outside of the Service Area, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance. In all other cases, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee for the amount up to the Prescription Drug Allowed Benefit, minus any applicable Deductible, or Copayment or Coinsurance.

I. When a Dependent Child is the subject of a Medical Child Support Order and the parent who is not the Subscriber incurs covered expenses on the child's behalf, CareFirst BlueChoice reserves the right to make payment for these covered expenses to the non-Subscriber parent, the provider, or the Maryland Department of Health and Mental Hygiene.

6.3 No Assignment. A Member cannot assign any benefits or payments due under this Agreement to any person, corporation or other organization, except as specifically provided by this Agreement or as required by law.

6.4 Legal Actions. A Member cannot bring any lawsuit against CareFirst BlueChoice to recover under this Agreement before the expiration of sixty (60) days after written proof of loss has been furnished, and not after three (3) years from the date that written proof of loss is required to be submitted to CareFirst BlueChoice.

6.5 Events Outside of CareFirst BlueChoice's Control. If CareFirst BlueChoice, for any reason beyond the control of CareFirst BlueChoice, is unable to provide the coverage promised under this Agreement, CareFirst BlueChoice is liable for reimbursement of the expenses necessarily incurred by any Member in procuring the services through other providers, to the extent prescribed by the Insurance Commissioner of Maryland.

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

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

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

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

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

6.8 Physical Examinations. CareFirst BlueChoice has the right to examine a Member when and as often as it may reasonably require during the pending of a claim under this Agreement. Any physical examination required by CareFirst BlueChoice will be performed at the expense of CareFirst BlueChoice.

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

6.10 CareFirst BlueChoice's Relationship to Providers. Health care providers, including Contracting Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers, are independent contractors or organizations and are related to CareFirst BlueChoice by contract only. Contracting Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers are not employees or agents of CareFirst BlueChoice and are not authorized to act on behalf of or obligate CareFirst BlueChoice with regard to interpretation of the terms of the Agreement, including eligibility of Members for coverage or entitlement to benefits. Contracting Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers maintain a provider-patient relationship with the Member and are solely responsible for the professional services they provide. CareFirst BlueChoice is not responsible for any acts or omissions, including those involving malpractice or wrongful death of Contracting Providers, Preferred or Participating Dentists, Contracting Vision Providers, Contracting Pharmacy Providers, or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

6.11 Provider and Services Information. Listings of current Contracting Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers will be

made available to Members at the time of enrollment. The listing of Contracting Providers, Preferred and Participating Dentists, Contracting Vision Providers and Contracting Pharmacy Providers is updated every fifteen (15) days on the CareFirst BlueChoice website (www.carefirst.com).

6.12 Selection of a Primary Care Physician.

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

B. A Member may change his or her Primary Care Physician at any time by notifying CareFirst BlueChoice. If the Member notifies CareFirst BlueChoice by the 20th day of the month, CareFirst BlueChoice will make the change effective the first day of the next month. If the Member notifies CareFirst BlueChoice after the twentieth (20^{th}) day of the month, CareFirst BlueChoice will make the change effective the first day of the second month following the notice.

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

1. The Member's Primary Care Physician is no longer available as a Primary Care Physician; or

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

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

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

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

D. If a change in Primary Care Physician is required, advance written notice will be given to the Member. The change is effective upon written notice to the Member. However, the Member may request a review of the action under the Benefit Determination and Appeal and Grievance Procedure.

6.13 Administration of Agreement. CareFirst BlueChoice may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

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

6.15 Records and Clerical Errors.

A. The Subscriber must furnish CareFirst BlueChoice data and notifications required for coverage in the format approved by CareFirst BlueChoice or the Exchange.

B. Clerical errors in recording or reporting data will not alter this Agreement. Upon discovery, adjustments will be made to remedy the errors.

6.16 Applicable Law. This Agreement is entered into and is subject to the laws of the State of Maryland. All claims arising from this Agreement will be brought and maintained in Maryland. Members and the Application Filer consent to Maryland jurisdiction for all actions arising from this Agreement.

6.17 Contestability of Agreement.

A. The Agreement may not be contested, except for nonpayment of Premium, after it has been in force for two (2) years from the date of issue;

B. Absent fraud, each statement made by an applicant or Member is considered to be a representation and not a warranty; and,

C. A statement to effectuate coverage may not be used to avoid the coverage or reduce the benefits unless:

1. The statement is contained in a written instrument signed by the Subscriber or Application Filer or Member, and

2. A copy of the statement is given to the Subscriber or Application Filer or Member.

No statement contained within this provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage or upon other provisions in this Agreement.

6.18 Misstatement of Age.

A. If the age of a Member has been misstated, all Premiums payable under this Agreement shall be equitably adjusted based on the Premium due based on the Member's correct age. If the correction of the Member's age results in an increase in the Premium due, the Subscriber or Application Filer shall pay CareFirst BlueChoice or the Exchange the increased Premium due by the next Premium Due Date after notification by CareFirst BlueChoice or the Exchange. If, due to the correction in the Member's age, a Subscriber or Application Filer has paid a Premium, or portion of a Premium, not due, CareFirst BlueChoice's liability is limited to a refund, on request, of any excess Premium paid for the period during which the Member's age was misstated.

B. The Agreement establishes a Limiting Age after which an enrolled Dependent Child will no longer be eligible for coverage. Likewise, Section 2.1 herein establishes an age beyond which a Subscriber is not eligible to enroll in Child-Only Coverage. If the age of the Member is misstated and, according to the correct age of the Member, the coverage provided by the Agreement would not have become effective or would have ceased before the acceptance of the Premium for the Agreement, CareFirst BlueChoice's liability is limited to a refund, on request, of the Premium paid for the period not covered by the Agreement, net of any benefits paid by CareFirst BlueChoice based on the Member's misstated age.

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

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

applicable.

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

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

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

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

6.20 Notices.

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

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

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065

1. Notice will be effective on the date of receipt by CareFirst BlueChoice, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the United States Postal Service.

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

6.21 Notice of Address Change. The Subscriber must notify CareFirst BlueChoice within fifteen (15) days of a change in residence or change in e-mail address, if the Member has consented to receive notices via electronic mail, or as soon as reasonably possible. Except in the case of a covered child who does not reside with the Subscriber, CareFirst BlueChoice is only responsible for mailing notices or correspondence to the last known physical address or e-mail address of the Subscriber.

6.22 Uniform Modification. CareFirst BlueChoice reserves the right to modify the Agreement at renewal if the modification is consistent with State law and is effective uniformly for all individuals with this product.

A. For purposes of this provision, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:

1. The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and

2. The modification is directly related to the imposition or modification of the Federal or State requirement.

B. For purposes of this provision, other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product meets all of the following criteria:

1. The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act);

2. The product is offered as the same product network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);

3. The product continues to cover at least a majority of the same service area;

4. Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and

5. The product provides the same covered benefits, except for any changes in benefits that cumulatively impact rate for any plan within the product within an allowable variation of ± 2 percentage points (not including changes pursuant to applicable Federal or State requirements).

6.23 Amendment Procedure. Except for Premium rate changes, CareFirst BlueChoice will amend this Agreement to implement modifications made pursuant to Section 6.22 by mailing a notice of the amendment(s) to the Subscriber, via first class mail or electronically if the Member has consented to receive such notices via electronic mail before the date of the first day of the next annual open enrollment period.

If the material modification required by law is made at a time other than renewal, and if it affects the content of the summary of benefits and coverage, CareFirst BlueChoice will provide advance notice at least sixty (60) days before the effective date of the modification.

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

6.24 Agreement Solely Between the Subscriber and CareFirst BlueChoice. The Subscriber, on behalf of himself/herself and the Subscriber's Dependents or the Application Filer, hereby expressly acknowledges the Subscriber's understanding that this Agreement constitutes a contract solely between the Subscriber and CareFirst BlueChoice; that CareFirst BlueChoice is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association) permitting CareFirst BlueChoice to use the Blue Cross and Blue Shield Service Marks in the District of Columbia, the State of Maryland and portions of the Commonwealth of Virginia and that CareFirst BlueChoice is not contracting as the agent of the Association. The Subscriber, on behalf of himself/herself and the Subscriber's Dependents or the Application Filer, further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than CareFirst BlueChoice; and no person, entity, or organization other than CareFirst BlueChoice shall be held accountable or liable to the Subscriber or the Application Filer for any of CareFirst BlueChoice's obligations to the Subscriber created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of CareFirst BlueChoice other than those obligations created under other provisions of this Agreement.

6.25 Complaints about CareFirst BlueChoice. Members or the Application Filer may complain to the Maryland Insurance Administration about the operation of CareFirst BlueChoice, Inc. Such complaints would include matters other than coverage decisions or adverse decisions as described in Attachment A, Benefit Determination and Appeal and Grievance Procedures. To complain about the operation of CareFirst BlueChoice, Members or the Application Filer should contact:

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

SECTION 7
SERVICE AREA

CareFirst BlueChoice's Service Area is a clearly defined geographic area in which CareFirst BlueChoice has arranged for the provision of health care services to be generally available and readily accessible to Members. CareFirst BlueChoice will provide the Member with a specific description of the Service Area at the time of enrollment.

The Service Area is as follows: the District of Columbia; the State of Maryland; in the State of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince Williams Counties in Virginia lying east of Route 123.

If a Member temporarily lives out of the Service Area (for example, if a Dependent goes to college in another state), the Member may be able to take advantage of the CareFirst BlueChoice Away From Home Program. This Program may allow a Member who resides out of the Service Area for an extended period of time to utilize the benefits of an affiliated Blue Cross and Blue Shield HMO. This Program is not coordination of benefits. **A Member who takes advantage of the Away From Home Program will be subject to the rules, regulations and plan benefits of the affiliated Blue Cross and Blue Shield HMO.** If the Member makes a permanent move, he/she does not have to wait until the Annual Open Enrollment Period to change plans. Please call 888-452-6403 or visit www.bcbs.com for more information on the Away from Home Program.

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

BENEFIT DETERMINATION AND APPEAL AND GRIEVANCE PROCEDURES AMENDMENT

This amendment is effective on the effective date or renewal date of the Agreement to which this amendment is attached.

The Agreement is amended as follows:

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

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

These procedures only apply to Claims for Benefits. Notification required by these procedures will only be sent when a Member requests a benefit or files a claim in accordance with the Plan's procedures.

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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 Member'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).

Adverse Decision means a utilization review determination that:

1. A proposed or delivered health care service covered under the Member's contract is or was not Medically Necessary, appropriate, or efficient; and

2. May result in non-coverage of the health care service. Adverse Decision does not include a Coverage Decision.

Appeal means a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan under its internal appeal process regarding a Coverage Decision.

Appeal Decision means final determination by the Plan that arises from an Appeal.

Claim for Benefits means a request for a Plan benefit or benefits made by a Member 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.

Claim Involving Urgent Care means any claim for medical care or treatment that involves an Emergency Case or an Urgent Medical Condition. 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 Member'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.

Claims Procedures means, collectively, the procedures governing the filing of benefit claims, Notification of benefit determinations, and Grievances and Appeals of Adverse Benefit Determinations for Members.

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

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

Coverage Decision means:

1. An initial determination by the Plan or the Plan's Designee that results in non-coverage of a health care service;

2. An determination by the Plan that that an individual is not eligible for coverage under the Agreement; or

3. A determination by the Plan that results in the Rescission of an individual's coverage under the Agreement.

A Coverage Decision includes nonpayment of all or part of a Claim for Benefits. A Coverage Decision does not include an Adverse Decision or a Pharmacy Inquiry.

Designee of the Commissioner means any person to whom the Commissioner has delegated the authority to review and decide Complaints, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

Emergency Case means medical services are necessary to treat a condition or illness that, without immediate medical attention, would either (i) seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, or (ii) cause the Member to be in danger to self or others.

Filing Date means the earlier of:

1. 5 days after the date of mailing; or

2. The date of receipt.

Grievance means a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member through the Plan's internal Grievance process regarding an Adverse Decision.

Grievance Decision means a final determination by the Plan that arises from a Grievance.

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

Health Care Provider, as used in this amendment, means:

1. An individual who is licensed under the Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the Member; or

2. A hospital as defined in Title 19 Subtitle 3 of the Health-General Article.

Member, as used in this amendment, means an individual entitled to receive health care benefits under this Agreement.

Member's Representative means an individual who has been authorized by a Member to file a Grievance, Appeal or a Complaint on behalf of a Member.

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.

Pharmacy Inquiry means an inquiry submitted by a pharmacist or pharmacy on behalf of a Member to the Plan, Plan Designee or pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under the Plan.

Plan means CareFirst BlueChoice.

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

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 Member'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 Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

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

Urgent Medical Condition means a condition that satisfies either of the following:

1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected 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, to result in:

   a. Placing the member's life or health in serious jeopardy;

   b. The inability of the member to regain maximum function;

   c. Serious impairment to bodily function;

   d. Serious dysfunction of any bodily organ or part; or
   e. The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or

2. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

B. SCOPE

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.

C. CLAIMS PROCEDURES

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeals and Grievances of Adverse Benefit Determinations (hereinafter collectively referred to as

Claims Procedures) for Members.

These Claims Procedures do not preclude a Member's Representative or Health Care Provider acting on behalf of a Member from acting on behalf of such Member in pursuing a Claim for Benefits, Grievance or Appeal of an Adverse Benefit Determination, or a Complaint to the Maryland Insurance Commissioner. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member.

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

D. CLAIMS PROCEDURES COMPLIANCE

1. Failure to follow Pre-Service Claims Procedures. In the case of a failure by a Member or a Member's Representative to follow the Plan's procedures for filing a Pre-Service Claim the Member 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 Member, the Member's Representative, or Health Care Provider acting on behalf of the Member, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member.

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

   a. Is a communication by a Member, the Member's Representative, or Health Care Provider acting on behalf of the Member that is received by the person or organizational unit designated by the Plan or Plan Designee that handles Claims for Benefits; and

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

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

E. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

1. In general. Except as provided in paragraph E.2 below, if a claim is wholly or partially denied, the Member 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 by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim (for example, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or the claim is not clean and the specific information necessary for the claim to be considered a clean claim). If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Member prior to the termination of the initial 30-day period. In no event shall such extension exceed a period of 30 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.

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

   a. Expedited Notification of benefit determinations relating to Claims Involving Urgent Care. In the case of a Claim Involving Urgent Care, the Member shall be

notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim unless the Member 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 Member 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 Member shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Member shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

i. Receipt of the specified information, or

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

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

i. Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Member shall be notified in accordance with paragraph E.2.e herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

ii. Any request by a Member 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 Member 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 an Appeal shall be governed by paragraphs G.2, G.3 and G.4 herein as appropriate.

iii. If a health care service for a Member has been preauthorized or approved by the Plan or the Plan's Designee, the Plan may not deny reimbursement to the Health Care Provider for the preauthorized or approved service delivered to the Member unless:

1) The information submitted regarding the service was fraudulent or intentionally misrepresentative;

2) Critical information required by the Plan or the Plan's Designee was omitted such that the Plan or Plan Designee's determination would have been different had it known the critical information;

3) A planned course of treatment for the Member was not substantially followed by the Health Care Provider; or

4) On the date the preauthorized service was delivered:

a) the Member was not covered by the Plan;

b) the Plan or the Plan's Designee maintained an automated eligibility verification system that was available to the Provider by telephone or via the Internet; and

c) according to the verification system, the Claimant was not covered by the Plan.

iv. Continued coverage will be provided pending the outcome of an appeal.

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

i. Pre-Service Claims. In the case of a Pre-Service Claim, the Member 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 Member, 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 Member to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph G. herein.

Authorization of Pre-Service Claims. The Plan or the Plan's Designee will determine whether to authorize or certify a Pre-Service Claim within 2 working days following receipt of all necessary information. If information is needed to make a decision which was not included in the initial request for authorization or certification, the Plan or the Plan's Designee will notify the Health Care Provider within 3 calendar days of the initial request that additional information is needed.

ii. Post-Service Claims. In the case of a Post-Service Claim, the Member shall be notified, in accordance with paragraph G. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary and notifies the Member, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary, the Plan or the Plan's Designee will send a Notice of receipt and status of the claim that states the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim. The Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

d. Rescission determinations. The Plan shall provide 30-days advance written Notice of any proposed Rescission of coverage for any individual.

e. 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 above due to a Member's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information.

F. MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

1. This section sets forth the manner and content of Notifications by the Plan of Adverse Benefit Determinations.

2. In the case of an Adverse Decision, the Plan or the Plan's Designee shall send a Member, the Member's Representative or Health Care Provider acting on behalf of the Member written or electronic Notification of any Adverse Benefit Determination. In the case of an Adverse Decision relating a Claim for Benefits that is not a Claim Involving Urgent Care, the Plan or the Plan's Designee shall send the written or electronic Notification within 5 working days after the Adverse Decision has been made. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider:

   a. The identity of the claim involved (including the date of service, the Health Care Provider, and the claim amount (if applicable)).

   b. The specific reason or reasons for the Adverse Decision;

   c. Reference to the specific Plan provisions on which the Adverse Decision is based;

   d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

   e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following an Adverse Decision;

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

   g. If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision , either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision and that a copy of such rule, guideline, protocol, diagnosis code (and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or

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

   i. In the case of an Adverse Decision 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. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

j. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Grievance Decision;

k. That a Complaint may be filed without first filing a Grievance if

i. The Plan notifies the Member in writing that it has waived the requirement that its internal grievance process be exhausted before filing a Complaint with the Commissioner;

ii. The Plan has failed to comply with any of the requirements of the internal grievance procedure described in this amendment; or

iii. the Member, the Member's Representative or Health Care Provider acting on behalf of the Member filing a Grievance on behalf of the Member can demonstrate a Compelling Reason to do so as determined by the Commissioner;

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

m. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance; and

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

3. In the case of a Coverage Decision, the Plan or the Plan Designee must within 30 calendar days provide Member, Member's Representative and the treating Health Care Provider, a written Notice of the Coverage Decision. The statement must state in detail, in clear, understandable language, the specific factual basis for the Plan's decision and must include the following information:

a. Where applicable, the identity of the claim involved (including the date of service, the Health Care Provider and the claim amount).

b. The specific reason or reasons for the Coverage Decision;

c. Reference to the specific Plan provisions on which the Coverage Decision is based;

d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following a Coverage Decision;

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

g. In the case of a Coverage Decision 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. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

h. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Appeal Decision;

i. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves a Claim Involving Urgent Care which has not been rendered;

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

k. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing an Appeal; and

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

4. Adverse Benefit Determinations are made under the direction of the Medical Director.

G. APPEALS AND GRIEVANCES OF ADVERSE BENEFIT DETERMINATIONS

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

   Mail Administrator
   P.O. Box 14114
   Lexington, KY 40512-4114
   410- 581-3000

   The Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance or Appeal. See Section K for additional information.

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

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

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

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

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

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

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

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

   e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal or Grievance of an Adverse Benefit Determination may be submitted orally or in writing by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member; and the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on

behalf of the Member of its determination in writing within 24 hours of receipt of the expedited request for Appeal or Grievance.

4. Full and fair review. The Plan or the Plan's Designee shall allow a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to review the claim file and to present evidence and written testimony as part of the internal claims and Appeals and Grievances 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 Member, the Member's Representative or Health Care Provider acting on behalf of the Member, 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 Grievance Decision or Appeal decision is required to be provided under paragraph H or I. herein, to give the Member a reasonable opportunity to respond prior to that date; and

   b. Before the Plan or the Plan's Designee issues a Grievance Decision or an Appeal Decision based on a new or additional rationale, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member 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 Appeal Decision or Grievance Decision is required to be provided under paragraphs H and I. herein, to give the Member, the Member's Representative or Health Care Provider acting on behalf of the Member a reasonable opportunity to respond prior to that date.

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

1. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its benefit determination on review of an Adverse Decision in accordance with the following, as appropriate.

   a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J. herein, of the Grievance Decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the Member's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 24 hours of the orally communicated Grievance Decision.

   b. Pre-service claims. In the case of a Pre-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J herein, of the Grievance Decision within a reasonable period of time appropriate to the medical circumstances. Oral Notification shall be provided not later than 30 days after the filing date of the Member, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.

   c. Post-service claims. In the case of a Post-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with item J herein, of the Grievance Decision within a reasonable period of time. Oral Notification shall be provided not later than 45 working days after the filing date of the Member's, the

Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.

2. If the Plan or the Plan's Designee does not have sufficient information to complete its Grievance Decision, the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within five (5) working days after the Filing Date of the Grievance by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan or the Plan's Designee. The Plan or the Plan's Designee Notification shall:

   a. Notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member that it cannot proceed with reviewing the Grievance unless additional information is provided; and

   b. Assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in gathering the necessary information without further delay.

3. The Plan or the Plan's Designee may extend the 30-day or 45-working day period required for making an Grievance Decision under paragraph H.1.b., c. with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.

4. Calculating time periods. For purposes of Section H. herein, the period of time within which a Grievance Decision shall be made begins at the time a Grievance 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 H.2 herein due to a Member's, the Member's Representative's or Health Care Provider '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 Member, the Member's Representative or Health Care Provider acting on behalf of the Member until the date on which the Member, the Member's Representative or Health Care Provider acting on behalf of the Member responds to the request for additional information.

5. In the case of Grievance, 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 G.2, G.3, and G.4 herein as is appropriate.

I. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS)

1. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its Appeal Decision no later than 60 working days after the filing date of the Member, the Member's Representative 's or Health Care Provider's Appeal. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 30 days of the Appeal Decision.

2. The Plan or the Plan's Designee may extend the 60-working day period required for making an Appeal Decision under I.1 with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who

filed the Appeal on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.

3. Calculating time periods. For purposes of Section I. herein, the 60-working day period within which a benefit determination on review shall be made, subject to any extension granted pursuant to paragraph I.2 above, 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 an Appeal Decision accompanies the filing.

J. MANNER AND CONTENT OF NOTIFICATION OF GRIEVANCE DECISION OR APPEAL DECISION

The Plan or the Plan's Designee shall provide a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with written or electronic Notification after it has provided oral communication of the Grievance Decision or Appeal Decision. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member:

1. The identity of the claim involved (including the date of service, the Health Care Provider and the claim amount (if applicable)).

2. The specific factual basis for the adverse determination;

3. Reference to the specific criteria and standards, including interpretive guidelines, on which the benefit determination is based;

4. A statement that the Member 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 Member's Claim For Benefits;

5. A statement describing any voluntary Appeal or Grievance procedures offered by the Plan and the Member's right to obtain the information about such procedures, and a statement of the Member's right to bring an action under Section 502(a) of the Act; and

6. a. If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination, either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, diagnosis code (and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or

   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 Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

   c. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available it so contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

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

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

   b. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Grievance Decision;

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

   d. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

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

   f. The Employee Benefit Security Administration's telephone number and website address; and

   g. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

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

   a. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Appeal Decision; and

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

   c. The Employee Benefit Security Administration's telephone number and website address; and

   d. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

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

   f. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

9. Grievance Decisions and Appeal Decisions are made under the direction of the Chief Medical Officer:

1501 S. Clinton Street
Baltimore, Maryland 21224
410- 581-3000

K. FILING OF COMPLAINT AFTER RECEIPT OF NOTIFICATION OF GRIEVANCE DECISIONS OR APPEAL DECISIONS

1. Within 4 months after the date of receipt of an Appeal Decision or a Grievance Decision, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner for review of the Grievance Decision or Appeal Decision.

2. A Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint without first exhausting the Plan's internal Grievance or Appeals process if:

   a. In the case of an Adverse Decision:

      i. The Plan or the Plan's Designee waives the requirement that the internal Grievance process be exhausted before filing a Complaint with the Commissioner;

      ii. The Plan or the Plan's Designee has failed to comply with any of the requirements of the internal Grievance process;

      iii. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member provides sufficient information and supporting documentation in the Complaint to demonstrate a Compelling Reason.

   b. In the case of a Coverage Decision, the Complaint involves an Urgent Medical Condition for which care has not been rendered.

3. The remaining provisions of this paragraph K. apply to Complaints regarding Adverse Decisions and Grievance Decisions.

   a. The Commissioner shall notify the Plan or the Plan's Designee of the Complaint within five working days after the date the Complaint is filed with the Commissioner.

   b. Except for an Emergency Case (Claim Involving Urgent Care), the Plan or the Plan's Designee shall provide to the Commissioner any information requested by the Commissioner no later than seven working days from the date the Plan or the Plan's Designee receives the request for information.

4. a. Except as provided in paragraph K.4.b below, the Commissioner shall make a final decision on a Complaint:

      i. Within 45 days after a Complaint is filed regarding a Pre-Service Claim;

      ii. Within 45 days after a Complaint is filed regarding a Post-Service Claim; and

      iii. Within 24 hours after a Complaint is filed regarding a Claim Involving Urgent Care.

   b. The Commissioner may extend the period within which a final decision is to be made under paragraph.K.4.a. for up to an additional 30 working days if:

i. the Commissioner has not yet received information requested by the Commissioner; and

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

5. The Commissioner shall seek advice from an independent review organization or medical expert for Complaints filed with the Commissioner that involve a question of whether a Pre-Service Claim or a Post-Service Claim is Medically Necessary. The Commissioner shall select an independent review organization or medical expert to advise on the Complaint in the manner set forth in Section 15-10A-05 of the Insurance Article.

6. The Plan or the Plan's Designee shall have the burden of persuasion that its Adverse Decision or Grievance, as applicable, is correct during the review of a Complaint by the Commissioner or Designee of the Commissioner, and in any hearing held regarding the Complaint.

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

8. Except as provided below, in responding to a Complaint, the Plan or the Plan's Designee may not rely on any basis not stated in its Adverse Benefit Determination.

   a. The Commissioner may allow the Plan or the Plan's Designee, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to provide additional information as may be relevant for the Commissioner to make a final decision on the Complaint.

   b. The Commissioner shall allow the Member, the Member's Representative or Health Care Provider acting on behalf of the Member at least 5 working days to provide the additional information.

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

9. The Commissioner may request the Member or a legally authorized designee of the Member to sign a consent form authorizing the release of the Member's medical records to the Commissioner or Designee of the Commissioner that are needed in order for the Commissioner to make a final decision on the Complaint.

10. Subject to paragraphs H, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner if the Member, the Member's Representative or Health Care Provider acting on behalf of the Member does not receive the Plan's Grievance Decision within the following timeframes:

    a. Within 30 days after the filing date of a Grievance regarding a Pre-Service Claim;

    b. Within 45 working days after the filing date of a Grievance regarding a Post-Service Claim; and

    c. Within 24 hours after the receipt of a Grievance regarding a Claim Involving Urgent Care.

Note: the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance. Contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor

Baltimore, MD 21202
410- 528-1840 or 1-877- 261-8807
Fax: 410- 576-6571
E-mail: heau@oag.state.md.us

L. MEMBER COMMENTS AND QUALITY COMPLAINTS

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

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

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

Maryland Insurance Administration
Inquiry and Investigation, Life and Health
200 St. Paul Place
Suite 2700
Baltimore, MD 21202-2272
410-468-2244

M. DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEAL PROCESS

If the Plan fails to adhere to the minimum requirements for Claims Procedures relating to Claims for Benefits by Members or Section 15-10A-02 of the Insurance Code, Annotated Code of Maryland, the Member is deemed to have exhausted the internal appeals and grievance processes of paragraph G through J herein. Accordingly the Member may initiate an external review under paragraph K of this section. The Member is also entitled, where applicable, to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the Claim for Benefits. If a Member, where applicable, chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the Claim for Benefits, Grievance, or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

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

CareFirst BlueChoice, Inc.

[Signature]

_____

[Name]
[Title]

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT B
DESCRIPTION OF COVERED SERVICES – HEALTH MAINTENANCE ORGANIZATION

The services described herein are eligible for coverage under the Agreement. CareFirst BlueChoice will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services, Covered Dental Services and Covered Vision 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, Prescription Drug Allowed Benefit, Vision Allowed Benefit or Pediatric Dental Allowed Benefit that CareFirst BlueChoice will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists important information about Deductibles, the Out-of- Pocket Maximum, and other features that affect Member coverage, including specific benefit limitations.

Refer to the Individual Enrollment Agreement for additional definitions of capitalized terms included in this Description of Covered Services.

CareFirst BlueChoice, Inc.

SECTION 1
OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES

CareFirst BlueChoice provides coverage for the services listed below in Contracting Providers' offices or in other Contracting Provider facilities.

Prior authorization is required for all outpatient services performed in the outpatient department of a hospital, including but not limited to, outpatient surgery, specialty imaging, diagnostic, laboratory and x-ray services, Outpatient Rehabilitative Services, and Infusion Services. Benefits will not be approved at these locations if CareFirst BlueChoice determines that the procedure can be provided in a medically appropriate manner within a physician's office or other less intensive and less costly setting.

If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are not covered. Prior authorization is the responsibility of the contracting provider and a member cannot be held liable when a contracting provider fails to obtain prior authorization.

Prior authorization is not required for Clinic Visits/ Outpatient Services rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.

1.1 Office Visits. Benefits are available for office visits for diagnosis and treatment of a medical illness or injury, including care and consultation by Primary Care Physicians or other Contracting Providers.

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

A. It is the Member's responsibility to locate and utilize a Contracting Provider.

B. For purposes of this provision, specialty imaging includes MRI's, MRA's and MRS's, PET scans, CAT scans and nuclear medicine studies.

C. Sleep Studies.

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

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

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

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

Benefits for preventive care include the following:

A. Cancer Screening Services. Benefits include:

1. Prostate Cancer Screening. Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal exams:

   a) For men who are between forty (40) and seventy-five (75) years of age;

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

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

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

2. Colorectal Cancer Screening. Colorectal cancer screening provided in accordance with the latest guidelines issued by the American Cancer Society, including any medically appropriate pre-procedure consultation as well as any pathology examination on a polyp biopsy occurring during this preventive procedure.

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

4. Breast Cancer Screening. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. 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.

B. Chlamydia Screening Test.

1. Chlamydia Screening Test means any laboratory test that:

   a) Specifically detects for infection by one or more agents of chlamydia trachomatis; and

   b) Is approved for this purpose by the FDA.

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

3. Coverage will be provided for an annual routine Chlamydia Screening Test for women who are under the age of 20 years if they are sexually active and 20 years old or older if they have Multiple Risk Factors.

4. Coverage will be provided for an annual routine Chlamydia Screening test for men who have Multiple Risk Factors.

C. Human Papillomavirus Screening Test

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

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

D. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

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

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

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

E. Well Child Care. 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.

F. Women's' Preventive Services. With respect to women, to the extent not described in this provision, evidence-informed preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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

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

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

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

4. Office visits for the treatment of obesity.

H. Osteoporosis Prevention and Treatment Services.

1. Definitions

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

Qualified Individual, as used in this provision, means a Member:

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

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

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

d) With primary hyperparathyroidism; or,

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

2. Covered Benefits. Benefits for Bone Mass Measurement for the prevention, diagnosis, and treatment of osteoporosis are covered when requested by a health care provider for a Qualified Individual.

1.4 Professional Nutritional Counseling and Medical Nutrition Therapy. Benefits will be provided for all Medically Necessary nutritional counseling provided by a licensed dietician-nutritionist, physician, physician assistant or nurse practitioner for a Member at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition. Benefits will also be provided for all Medically Necessary medical nutrition therapy provided by a licensed dietician-nutritionist working in coordination with a primary care physician, to treat a chronic illness or condition.

1.5 Family Planning Services. Benefits will be provided for:

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

B. Nurse Midwife Services. A female Member may receive Medically Necessary obstetrical and gynecological care from a provider who is a certified nurse midwife or other health care practitioner authorized under state law to provide obstetrical and gynecological services.

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

C. Contraceptive Methods and Counseling. Benefits will be provided for:

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

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

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

4. Voluntary sterilization.

See Section 12, Prescription Drugs, for coverage for self-administered FDA- approved contraceptive drugs and devices.

D. Maternity and Related Services.

1. Preventive Services.

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

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

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

d) Breastfeeding support, supplies, and consultation.

2. Non-Preventive Services.

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

b) Birthing classes, one course per pregnancy, at a CareFirst BlueChoice approved facility;

c) Inpatient care for delivery;

d) Coverage for care rendered at a CareFirst BlueChoice-approved licensed birthing center;

e) Non-preventive routine professional services rendered to the newborn during a covered hospitalization for delivery. Non-routine care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as a Member in the newborn's own right. Section 2.6 in the Individual Enrollment Agreement describes the steps, if any, necessary to enroll a newborn Dependent Child. This section is not applicable to Child-Only Coverage.

f) Elective abortion.

3. Postpartum Home Visits. See Section 7.3C., Home Health Services.

E. Newborn Coverage. Coverage includes:

1. Professional services during a covered hospitalization rendered to the newborn;

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

3. Newborn audiology screening prior to discharge and one confirming screening.

F. Infertility Services. Benefits for Medically Necessary, non-Experimental/Investigational artificial insemination, intrauterine insemination and in-vitro fertilization are covered.

1. Benefits are limited to:

a) Infertility counseling;

b) Testing;

c) Assisted reproductive technologies as described and limited below.

2. Artificial Insemination and Intrauterine Insemination.

a) Benefits are available when:

(1) For a Member whose Spouse is of the opposite sex:

(a) The Member and the Member's Spouse have a history of the inability to conceive after one (1) year of unprotected vaginal intercourse and the Member's Spouse's sperm is used; and,

(b) The Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination; and,

(c) The Member's Spouse's sperm is used.

(2) For a Member whose Spouse is of the same sex, the Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination.

b) For a Member whose Spouse is of the opposite sex, any charges associated with the collection of the Member's Spouse's sperm will not be covered unless the Spouse is also a Member. For a Member whose Spouse is of the same sex, benefits will not be provided for costs incurred by the Member in obtaining donor sperm.

c) Limitations. Coverage for a treatment or procedure described in this section will only be provided to treat a diagnosed medical condition.

d) Prior authorization is required.

3. In-Vitro Fertilization (IVF).

a) Benefits are available when:

(1) For a Member whose Spouse is of the opposite sex, the oocytes (eggs) are physically produced by the Member and fertilized with sperm physically produced by the Member's Spouse, unless:

(a) the Member's Spouse in unable to produce and deliver functional sperm; and,

(b) the inability to produce and deliver functional sperm does not result from:

(i) a vasectomy; or

(ii) another method of voluntary sterilization.

(2) The Member and the Member's Spouse have a history of involuntary infertility which may be demonstrated by a history of:

(a) If the Member and the Member's Spouse are of the opposite sexes, the inability to conceive after at least two (2) years of unprotected vaginal intercourse failing to result in pregnancy; or

(b) If the Member and the Member's Spouse are of the same sex, six (6) attempts of artificial insemination over the course of two (2) years failing to result in pregnancy; or

(c) The infertility is associated with any of the following medical conditions:

(i) Endometriosis;

(ii) Exposure in utero to diethylstilbestrol, commonly known as DES;

(iii) Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or

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

(3) The Member has been unable to attain a successful pregnancy through less costly infertility treatment for which coverage is available under this Agreement; and

(4) The in vitro fertilization procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

b) Limitations.

(1) Benefits are available to the Subscriber or the dependent Spouse of the Subscriber.

(2) Benefits are limited to three (3) attempts per live birth.

(3) Coverage for a treatment or procedure described in this section will only be provided to treat a diagnosed medical condition.

(4) A lifetime maximum payment, if any, as stated in the Schedule of Benefits.

c) For a Member whose Spouse is of the opposite sex, any charges associated with the collection of the Member's Spouse's sperm will not be covered unless the Spouse is also a Member. For a Member whose Spouse is of the same sex or the Member's Spouse is of the opposite sex and cannot produce and deliver sperm, benefits will not be provided for costs incurred by the Member in obtaining donor sperm.

d) Prior authorization is required.

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

1.7 Diabetes Treatment.

A. Coverage will be provided for Medically Necessary diabetes treatment and outpatient self-management training and educational services, including medical nutritional counseling at a CareFirst BlueChoice approved facility. Diabetic Supplies are covered under Section 12 herein. Diabetic equipment is covered under Section 11 herein.

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

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

1.8 Outpatient Rehabilitative Services. Benefits will be provided for Outpatient Rehabilitative Services for the treatment of individuals who have sustained an illness or injury that CareFirst BlueChoice determines to be subject to improvement. The goal of Outpatient Rehabilitative Services is to return the individual to his/her prior skill and functional level.

1.9 Chiropractic Services. Benefits will be provided for Medically Necessary chiropractic services when provided by a licensed chiropractor, doctor of osteopathy (D.O.) or other eligible practitioner.

1.10 Habilitative Services.

A. Members until at least the end of the month in which the Member turns nineteen (19) years old.

1. Coverage for Habilitative services includes health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.

Examples include therapy for a child who is not walking or talking at the expected age. These services may include services for cleft lip and cleft palate, orthodontics, oral surgery, otologic, audiological, and speech therapy, physical therapy, occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

3. Benefits are not counted toward any visit maximum for Outpatient Rehabilitation Therapy services.

B. For Members age 19 and over.

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

2. Benefits are available to the same extent as benefits provided for Outpatient Rehabilitative Services.

C. Prior authorization is required.

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

1.12 Outpatient Therapeutic Treatment Services. Benefits are available for outpatient services rendered in a health care provider's office, in the outpatient department of a hospital, in an ambulatory surgical facility, or other facility in connection with a medical or surgical procedure covered under Section 1, Outpatient Facility, Office and Professional Services.

Benefits include:

A. Hemodialysis and peritoneal dialysis;

B. Radiation therapy, including radiation administration;

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

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

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

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

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

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

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

E. Infusion and transfusion services, including infusion of chemotherapeutic and therapeutic agents, medication and nutrients, enteral nutrition into the gastrointestinal tract, and prescription medications; and,

F. Radioisotope treatment.

1.13 Blood and Blood Products. Benefits are available for cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums, including: autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin.

1.14 Controlled Clinical Trials.

A. Covered Services.

Benefits will be provided to a Member in a Controlled Clinical Trial will be provided if the Member's participation in the Controlled Clinical Trial is the result of:

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

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

B. Coverage will be provided only if:

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

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

3. 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;

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

5. 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; and

6. Prior authorization has been obtained from CareFirst BlueChoice.

C. 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.

D. Benefits for covered Controlled Clinical Trials will be provided without regard to Service Area or Contracting Provider restrictions that otherwise apply to Covered Services.

1.15 Dental Services. Pediatric dental benefits for Members up to age nineteen (19) are described in Section 2. Benefits will be provided to all Members for the following:

A. Accidental Injury.

1. Covered Benefits. Dental benefits will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if the injury did not arise while or as a result of biting or chewing (except for Members under age 19) and treatment is commenced within six (6) months of the injury or, if due to the nature of the injury, treatment could not begin within six (6) months of the injury, treatment began within six (6) months of the earliest date that it would be medically appropriate to begin such treatment.

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

2. Conditions and Limitations. Benefits are limited to Medically Necessary dental services such as restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury. Except as listed here, or in Section 1.17 describing benefits for the treatment of cleft lip or cleft palate or both, or Section 2, Pediatric Dental Services, dental care is excluded from coverage. Benefits for oral surgery are described below.

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

1. If the Member is:

   a) Seven (7) years of age or younger, or developmentally disabled;

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

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

2. Or, if the Member is:

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

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

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

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

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

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

   a) A fully accredited specialist in pediatric dentistry;

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

c) A dentist who has been granted hospital privileges.

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

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

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

1.16 Oral Surgery. Benefits include:

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

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

C. Medically Necessary surgical treatment, as determined by CareFirst BlueChoice, for Temporomandibular Joint Syndrome (TMJ). Except as provided in Section 2, Pediatric Dental Services, all other treatments or procedures for the treatment of TMJ are excluded.

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

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

1.18 Outpatient Surgical Procedures.

A. Benefits are available for surgical procedures performed by health care providers on an outpatient basis.

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

1. Use of operating room and recovery room.

2. Use of special procedure rooms.

3. Diagnostic procedures, laboratory tests and radiology services.

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

5. Medical and surgical supplies.

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

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

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

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

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

1. Augmentation mammoplasty;

2. Reduction mammoplasty; and

3. Mastopexy.

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

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

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

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

Surgical treatment of Morbid Obesity shall occur at a facility that is designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence and is designated by CareFirst BlueChoice.

1.23 Wellness Benefits. Benefits will be provided for:

A. A health risk assessment that is completed by each Member on a voluntary basis; and,

B. Written feedback to the individual who completes the health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.

1.24. Retail Health Clinics. Coverage is provided for treatment of common conditions or ailments, which require rapid and specific treatment that can be administered in a limited duration of time. Retail Health Clinics are mini-medical office chains typically staffed by nurse practitioners with an on-call physician. Retail Health Clinic services are non-emergency and non-urgent services for common ailments for which a reasonable, prudent layperson who possesses an average knowledge of health and medicine would seek in a Retail Health Clinic, including, but not limited to: ear, bladder, and sinus infections, pink eye, flu, and strep throat.

1.25 Telemedicine.

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

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

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

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

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

SECTION 2
PEDIATRIC DENTAL SERVICES

2.1 Covered Dental Services. Pediatric dental benefits will be provided through the Dental Plan for Members up to the end of the Calendar Year in which the Member turns age 19 in accordance with the Maryland Children's Health Insurance Plan dental benefits, which includes benefits for periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry and as specified in the Schedule of Benefits.

2.2 Class I - Preventive and Diagnostic Services.

A. Services limited to twice per Benefit Period.

1. Oral examination including oral health risk assessment.
2. Routine cleaning of teeth (dental prophylaxis).
3. Topical application of fluoride.
4. Bite wing x-ray (not taken on the same date as those in 2.2C below)
5. Intraoral occlusal x-ray.
6. Pulp vitality tests; additional tests may be allowed for accidental injury and trauma, or other emergency.

B. Topical fluoride varnish (D1206) limited to eight (8) per twelve (12) months per Member ages zero to two(2) and four (4) per twelve (12) months per Member ages three (3) and above until the end of the Calendar Year in which the Member turns age nineteen (19).

C. Services limited to one per thirty-six (36) months:

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

D. Services limited to once per tooth per sixty (60) months: sealants on permanent molars.

E. Services limited to once per quadrant per twenty-four (24) months: space maintainers when Medically Necessary due to the premature loss of a posterior primary tooth.

F. Services as required.

1. Palliative treatments once per date of service.
2. Emergency oral exam once per date of service.
3. Periapical and occlusal x-rays limited to the site of injury or infection.
4. Professional consultation rendered by a Dentist, limited to one consultation per condition per Dentist other than the treating Dentist.
5. Temporomandibular joint (TMJ) arthograms, including injection, and other TMJ films, by report.

2.3 Class II - Basic Services.

A. Direct placement fillings, limited to:

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

2. One filling per twelve (12) months, per tooth, per surface

3. Direct pulp caps and indirect pulp caps

B. Non-Surgical periodontal services limited to:

1. Periodontal scaling and root planing one (1) per twenty-four (24) months per quadrant

2. Provision splinting, intracoronal and extracoronal

3. Full mouth debridement to enable comprehensive periodontal procedure once per twenty-four (24) months

4. Periodontal maintenance procedures two (2) per twelve (12) months

C. Simple extractions performed without general anesthesia limited to once per tooth per lifetime.

2.4 Class III - Major Services – Surgical.

A. Surgical periodontic services.

1. Gingivectomy or gingivoplasty limited to one (1) treatment per twenty-four (24) months per Member per quadrant or per tooth, and limited to two (2) quadrants per twelve (12) months.

2. Osseous surgery (including flap entry and closure) limited to one (1) treatment per twenty-four (24) months per Member per quadrant.

3. Mucogingival surgery limited to grafts and plastic procedures; one (1) treatment per site.

B. Endodontics

1. Apicoectomy, limited to one per Member, per tooth, per lifetime

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

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

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

5. Root resection.

6. Pulpal therapy limited to once per tooth per lifetime per Member.

7. Endodontic therapy limited to one per tooth per lifetime per Member.

C. Oral surgical services as required.

1. Simple and surgical extractions, including impactions once per tooth per lifetime per Member.

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

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

4. Hemi-section: one per Member, per tooth, per lifetime

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

6. Vestibuloplasty.

7. Services limited to once per lifetime per tooth:

a) Coronectomy.

b) Tooth transplantation.

c) Surgical repositioning of teeth.

d) Alveoloplasty.

e) Frenulectomy.

f) Excision of pericoronal gingiva.

D. Limited or complete occlusal adjustments.

E. In addition to the benefits stated in Section 1.15B, general anesthesia, intravenous (IV) sedation/analgesia, inhalation of nitrous oxide/anxiolysis, analgesia, and non-intravenous conscious sedation when Medically Necessary.

2.5 Class IV - Major Services – Restorative.

A. Crowns.

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

2. Metal and/or porcelain/ceramic inlays and onlays limited to one (1) per sixty (60) months per tooth.

3. Stainless steel crowns.

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

B. Dentures

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

2. Complete removable dentures, upper or lower, limited to one (1) per sixty (60) months.

3. Pre-operative radiographs required.

4. Pre-treatment estimate, as described in Section 14.7F, Estimate of Eligible Benefits, is recommended.

5. Tissue conditioning prior to denture impression only.

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

7. Adjust maxillofacial prosthetic appliance, by report, limited to one per six (6) months, per Member, per arch.

8. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, limited to one per six (6) months, per Member, per arch.

C. Denture adjustments and relining limited to: Full or partial removable (upper or lower) dentures: once per twenty-four (24) months, but not within six (6) months of initial placement

D. Repair of prosthetic appliances, including removable dentures, full and/or partial.

E. Occlusal guard, by report, limited to one (1) per twenty-four (24) months, per Member

F. Fabrication of athletic mouth guard limited to one (1) per twelve (12) months.

2.6 Class V - Orthodontic Services.

A. Benefits for orthodontic services will only be available if the Member:

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

2. Has a severe, dysfunctional, handicapping malocclusion that meets a minimum score of 15 on the Handicapping Labio-Lingual Deviations Index (HLD) approved for use by the State of Maryland. Points are not awarded for aesthetics, therefore additional points for handicapping aesthetics will not be considered as part of the determination.

B. All orthodontic services require a pre-treatment estimate (PTE) to be submitted to the Dental Plan as described in Section 15.6F, Estimate of Eligible Benefits. The following documentation must be submitted with the PTE:

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

2. Diagnostic study models (trimmed) with wax bites or OrthoCAD™ electronic equivalent,

3. Cephalometric head film with measurements and analysis;

4. Panoramic or full series periapical radiographs;

5. Clinical summary with diagnosis;

6. HLD score sheet completed and signed by the orthodontist; and

7. Treatment plan including anticipated duration of active treatment.

C. Covered benefits if the PTE is approved by the Dental Plan:

1. Retainers:

a) One (1) set (included in comprehensive orthodontics);

b) Replacement allowed one per arch per lifetime within twenty-four (24) months of date of debanding, if necessary; and,

c) Rebonding or recementing fixed retainer.

2. Pre-orthodontic treatment visit.

3. Braces limited to once per lifetime

4. Periodic treatment visits; not to exceed twenty-four (24) months. The Member must be eligible for Covered Dental Services on each date of service, except as specifically stated in the Extension of Benefits section of the Individual Enrollment Agreement.

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

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

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

SECTION 3
PEDIATRIC VISION SERVICES

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

A. One (1) routine eye examination, including dilation, if professionally indicated, each Benefit Period. A vision examination may include, but is not limited to:

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

B. Frames and Spectacle Lenses or Contact Lenses

1. Prescribed frames and spectacle lenses or contact lenses, including directly related provider services such as:
   a) Measurement of face and interpupillary distance;
   b) Quality assurance; and
   c) Reasonable aftercare to fit, adjust and maintain comfort and effectiveness.
2. One pair of frames per Benefit Period; and
3. One pair of prescription spectacle lenses per Benefit Period
   a) Spectacle lenses include choice of glass or plastic lenses and, all lens powers (single vision, bifocal, trifocal, lenticular). Fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, ultraviolet protective coating, standard progressives, and plastic photosensitive lenses (Transitions®) are non-Covered Vision Services.
   b) Scratch resistant coating.
4. Contact Lenses
   a) Contact lens evaluation, fitting, and follow-up care.

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

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

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

c) One (1) pair of Medically Necessary Contact Lenses per Benefit Period in lieu of other eyewear.

(1) Prior authorization is required. Contracting Vision Providers will obtain the necessary prior authorization for these services. For services provided by Non-Contracting Vision Providers, the Member is responsible for obtaining prior authorization from the Vision Care Designee by calling the Vision Care Designee at the telephone number on the Member's identification card.

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

C. Low vision services, including one (1) comprehensive Low Vision evaluation every five (5) years, four (4) follow-up visits in any five (5)-year period and prescribed optical devices, such as high-powered spectacles, magnifiers and telescopes.

1. Ophthalmologists and optometrists specializing in low vision care will evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with low vision.

2. Prior authorization is required. Contracting Vision Providers will obtain the necessary prior authorization for these services. For services provided by Non-Contracting Vision Providers, the Member is responsible for obtaining prior authorization from the Vision Care Designee by calling the Vision Care Designee at the telephone number on the Member's identification card.

D. Covered Vision Services are limited as stated in the Schedule of Benefits.

3.2 Warranty. The Vision Care Designee's collection frames and all eyeglass lenses manufactured in the Vision Care Designee laboratories are guaranteed for one (1) year from the original date of dispensing. Warranty limitations may apply to provider-supplied or retailer- supplied frames and/or eyeglass lenses. The Contracting Vision Provider can provide the details of the warranty that is available to the Member.

3.3 Limitations. Benefit limited to Members up to age nineteen (19). If Member is under age nineteen (19) at the start of the Benefit Period but turns nineteen (19) during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year. Benefits for treatment of medical conditions of the eye are covered under Section 1. Add-ons to basic spectacle lenses are not covered under this Agreement. Non-collection frames and non-collection contact lenses are not covered when obtained from a Contracting Vision Provider.

SECTION 4
ADULT VISION SERVICES

4.1 Covered Vision Services. Coverage will be provided for Members age 19 and over for one (1) routine eye examination, including dilation, if professionally indicated, each Benefit Period. A vision examination may include, but is not limited to:

A. Case history;

B. External examination of the eye and adnexa;

C. Ophthalmoscopic examination;

D. Determination of refractive status;

E. Binocular balance testing;

F. Tonometry test for glaucoma;

G. Gross visual field testing;

H. Color vision testing;

I. Summary finding; and

J. Recommendation, including prescription of corrective lenses.

4.2 Limitations. Benefits will not be provided for frames, lenses and contact lenses. Benefits for treatment of medical conditions of the eye are covered under Section 1.

SECTION 5
INPATIENT HOSPITAL SERVICES

HOSPITAL ADMISSIONS MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE, UNLESS EXCEPTIONS ARE STATED.

CareFirst BlueChoice provides coverage for the services listed below in a Contracting Provider Hospital when admitted under the care of a Primary Care Physician or other Contracting Provider.

5.1 Covered Inpatient Hospital Services. A Member will receive benefits for the Covered Services listed below when admitted to a Contracting Provider hospital under the care of a Primary Care Physician or other Contracting Provider. Coverage of inpatient hospital services is subject to certification by utilization management for Medical Necessity. Except for maternity and Emergency admissions, prior authorization is required. Contracting Providers will obtain prior authorization on behalf of the Member. Benefits are provided for:

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

B. Physician and Medical Services. Medically Necessary inpatient physician and medical services provided by or under the direction of the attending health care provider and ordinarily furnished to a patient while hospitalized.

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

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

1. The use of:

a) Operating rooms;

b) Treatment rooms; and

c) Special equipment in the hospital.

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

3. Medical and surgical supplies.

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

5. Surgically implanted Prosthetic devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants and pacemakers. Available benefits under this provision do not include items such as artificial limbs or eyes, hearing aids, or other external prosthetics, which may be provided under other provisions of the Description of Covered Services.

6. Medical social services.

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

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

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

2. Twenty-four (24) hours following a partial Mastectomy with lymph node dissection.

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

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

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

2. Not less than forty-eight (48) hours for a vaginal hysterectomy.

In consultation with the health care provider, the Member may elect to stay less than the minimum prescribed above when appropriate.

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

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

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

Prior authorization is not required for maternity admissions.

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

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

Non-routine care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as a Member in the newborn's own right. Section 2.6 of the Individual Enrollment Agreement describes the steps, if any, necessary to enroll a newborn Dependent Child. This section is not applicable to a Child-Only Agreement.

5.3 Organ and Tissue Transplants.

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

and kidney transplants, prior authorization must be obtained from CareFirst BlueChoice.

B. Covered services include the following:

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

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

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

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

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

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

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

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

5.5 Inpatient Hospital Pre-Admission Review. When the Member's Medicare coverage is primary coverage to this CareFirst BlueChoice plan, prior authorization for inpatient hospital services will not be required. Coverage of inpatient hospital services is subject to the requirements for pre-admission review, concurrent review, and discharge planning for all covered hospitalizations. Such review and approval will determine:

A. The need for hospitalization;

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

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

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

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

SECTION 6
SKILLED NURSING FACILITY SERVICES

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

CareFirst BlueChoice provides coverage for the services listed below in a Contracting Provider Skilled Nursing Facility when admitted under the care of a Primary Care Physician or other Contracting Provider. Prior authorization is required.

6.1 Covered Skilled Nursing Facility Services. When the Member meets the conditions for coverage listed in Section 6.2, the services listed below are available to Members in a Skilled Nursing Facility:

A. Room and board in a semiprivate room;

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

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

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

A. The Member must be under the care of his or her primary care physician or other Contracting Provider.

B. The admission to the Skilled Nursing Facility must be a substitute for hospital care (i.e., if the Member were not admitted to a Skilled Nursing Facility, he or she would have to be admitted to a hospital).

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

D. The Member must require Skilled Nursing Care or skilled rehabilitation services which are:

1. Required on a daily basis;

2. Not Custodial; and,

3. Only provided on an inpatient basis.

E. Prior authorization has been obtained from CareFirst BlueChoice.

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

A. A Member cannot self-administer the care;

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

C. Ordered by a physician;

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

E. Covered by Medicare.

SECTION 7
HOME HEALTH CARE SERVICES

HOME HEALTH CARE SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

CareFirst BlueChoice provides coverage for the services listed below in a Member's home by a Contracting Provider Home Health Agency when authorized or approved by CareFirst BlueChoice.

7.1 Covered Home Health Services. Benefits are provided for:

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

B. Drugs and medications:

1. Directly administered to the patient during a covered home health visit and incidental Medical Supplies directly expended in the course of a covered home health visit; and,

2. Drugs, medications and Medical Supplies for home use. Purchase or rental of Durable Medical Equipment is not covered under this provision. See Section 11.1A, Durable Medical Equipment, for benefit information.

C. Home Health Services authorized or approved by CareFirst BlueChoice as Medically Necessary.

D. Prior authorization for Home Health Care Services is required.

7.2 Conditions for Coverage. Benefits are provided when:

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

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

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

D. The need for Home Health Care Services is not Custodial in nature.

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

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

G. The Member must be under the care of a Primary Care Physician or other Contracting Physician.

H. Prior authorization has been obtained from CareFirst BlueChoice.

7.3 Additional Home Health Care Benefits.

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

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

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

3. Prior authorization is not required.

B. Home Visits Following Mastectomy. For a Member who receives less than 48 hours of inpatient hospitalization following the Mastectomy, or who undergoes the Mastectomy on an outpatient basis, benefits will be provided for:

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

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

3. Prior authorization is not required.

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

1. For a mother and newborn child who have a shorter hospital stay than that provided under Section 5.2C, Childbirth, benefits will be provided for:

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

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

2. For a mother and newborn child who remain in the hospital for at least the length of time provided under Section 5.2C, Childbirth, benefits will be provided for a home visit if prescribed by the attending provider.

3. Prior authorization is not required.

SECTION 8
HOSPICE CARE SERVICES

HOSPICE CARE SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

8.1 Covered Hospice Care Services. Benefits will be provided for terminally ill Members for the services listed below when provided by a Qualified Hospice Care Program. Prior authorization is required.

A. Inpatient and outpatient care;

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

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

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

E. Non-Custodial home health visits;

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

G. Laboratory test and x-ray services;

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

I. Respite Care;

J. Family Counseling will be provided to the Immediate Family and the Family Caregiver before the death of the terminally ill Member, when authorized or approved by CareFirst BlueChoice; and

K. Bereavement Counseling.

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

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

B. The Member's attending Contracting Provider must submit a written hospice care services Plan of Treatment to CareFirst BlueChoice;

C. The Member must meet the criteria of the Qualified Hospice Care Program;

D. Prior authorization has been obtained from CareFirst BlueChoice; and

E. The need and continued appropriateness of hospice care services is subject to concurrent review.

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

SECTION 9
INPATIENT AND OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

HOSPITAL ADMISSIONS MUST BE AUTHORIZED ORAPPROVED BY THE MENTAL HEALTH AND SUBSTANCE ABUSE MANAGEMENT PROGRAM. PRIOR AUHTORIZATION WILL BE OBTAINED BY CONTRACTING PROVIDERS

9.1 Professional Services. Professional services rendered by licensed, certified or registered professional mental health and substance abuse practitioners when acting within the scope of his/her license, certification or registration, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Benefits provided under this Agreement are limited to Covered Services rendered by Contracting Providers.

A. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:

1. Diagnostic evaluation;

2. Crisis intervention and stabilization for acute episodes;

3. Medication evaluation and management (pharmacotherapy);

4. Treatment and counseling (including partial hospitalization and individual and group therapy visits);

5. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling; and

6. Professional charges for intensive outpatient treatment in a provider's office or other professional setting.

B. Electroconvulsive therapy;

C. Inpatient and outpatient professional fees.

D. Outpatient diagnostic tests provided and billed by a licensed, certified or registered mental health and substance abuse practitioner;

E. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility;

F. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.

9.2 Inpatient Hospital and Inpatient Residential Treatment Centers Services. Coverage will be provided for:

A. Room and board such as:

1. Ward, semiprivate or intensive care accommodations. Private room is covered only if Medically Necessary. If a private room is not Medically Necessary, CareFirst BlueChoice will only cover the hospital's average charge for semiprivate accommodations.

2. General nursing care; and

3. Meals and special diets.

B. Other facility services and supplies. Services provided by a hospital or residential treatment center (RTC).

9.3. Outpatient Facility Services. Benefits will be provided for Covered Services rendered by a Contracting Provider including, but not limited to, partial hospitalization or intensive day treatment programs.

9.4. Emergency Room Services. Outpatient services and supplies billed by a hospital for emergency room treatment.

SECTION 10
EMERGENCY SERVICES AND URGENT CARE

CareFirst BlueChoice provides coverage for the services listed below at Hospital emergency rooms and Urgent Care facilities inside or outside of the Service Area.

10.1 Emergency Services and Urgent Care.

A. Benefits are available to a Member for Emergency Services and Urgent Care twenty-four (24) hours per day regardless of whether rendered inside or outside of the Service Area.

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

1. The need for care could not reasonably have been foreseen before departing the Service Area or sufficiently in advance so as to permit the Member to return to the Service Area for the care before it became urgent;

2. The care was urgently required to alleviate acute pain or prevent further significant deterioration of the Member's condition;

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

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

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

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

1. Appropriate medical screening;

2. Assessment and stabilization services;

3. Ancillary services routinely available to the emergency department to determine whether or not an Emergency Medical Condition exists; and

4. Medically Necessary observation to determine whether the Member's condition requires inpatient hospitalization.

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

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

E. Except as provided in Section 10.5, benefits are not provided for routine follow-up treatment within the Service Area provided by Non-Contracting Providers. Follow-up treatment outside of the Service Area is covered if required in connection with covered out-of-area Emergency Services or Urgent Care and CareFirst BlueChoice determines that the member could not reasonably be expected to return to the Service Area for such care.

10.2 Notice to CareFirst BlueChoice in the Event of an Emergency.

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

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

2. Within forty-eight (48) hours after first receiving the care.

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

10.3 Emergency Ambulance Services.

A. Benefits are available for Medically Necessary ambulance services to the nearest facility where appropriate medical care is available for treatment for Emergency Services.

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

10.4 Non-Emergency Ambulance Services. Benefits are available for non-emergency ambulance services that are provided by a Contracting Provider and are Medically Necessary, as determined by CareFirst BlueChoice. Routine transport services are considered not Medically Necessary. The use of an air ambulance for non-emergency ambulance services requires a prior authorization.

10.5 Filing a Claim for a Non-Contracting Provider. Members may receive Emergency Services, Urgent Care, Emergency Ambulance Services, or follow-up care after emergency Surgery from a Non-Contracting Provider. When a Member receives Emergency Services, Urgent Care, or follow-up care after emergency surgery from a Non-Contracting Provider, the Member must follow the proof of loss requirements of Section 6.2B of the Individual Enrollment Agreement.

10.6 Follow-up Care After Emergency Surgery. If CareFirst BlueChoice authorizes, directs, refers, or otherwise allows a Member to access a hospital emergency facility or other Urgent Care facility for a medical condition that meets the criteria for Emergency Services and the Member requires emergency surgery:

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

B. The Member will be responsible for the same Copayment or Coinsurance for each follow-up visit as would be required for a visit to a Contracting Provider for specialty care.

SECTION 11
MEDICAL DEVICES AND SUPPLIES

CareFirst BlueChoice provides benefits for Medical Devices and Supplies obtained through designated Contracting Providers.

11.1 Covered Services. Benefits will be provided for:

A. Durable Medical Equipment including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses.

B. Breast Prostheses. Coverage will be provided for prostheses for a Member who has undergone a Mastectomy and has not had breast reconstruction.

C. Medical food for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders.

D. Hearing aids. Coverage will be provided for one hearing aid for each hearing-impaired ear every 36 months.

E Diabetes Equipment and Supplies.

1. Diabetes equipment includes glucose monitoring equipment under the durable medical equipment coverage for insulin-using beneficiaries. Coverage will be provided for insulin pumps.

2. Diabetes supplies include coverage for insulin syringes and needles and testing strips for glucose monitoring equipment under the Prescription Drug coverage for insulin-using beneficiaries.

3. Insulin using beneficiary means a Member who uses insulin as part of a treatment plan prescribed by his/her medical care provider.

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

11.2 Authorization or Approval of Medical Devices and Supplies by CareFirst BlueChoice. Prior authorization is required for the following covered Medical Devices and Supplies:

A. Beds. Specialty beds such as heavy duty, pediatric, extra wide, and specialty mattresses

B. Prosthetic devices (except Prosthetic legs, arms or eyes).

1. Microprocessor limbs.

2. Cochlear implants.

3. Speech generating devices.

C. Respiratory devices.

1. Oral airway devices.

2. Apnea monitors.

D. Mobility devices, wheelchairs (power and/or custom), and power-operated vehicles.

E. Phototherapy devices.

F. Specialty Medical Devices and Equipment.

1. Defibrillators.

2. Wound therapy electrical pumps.

3. Continuous glucose monitoring devices.

G. Repairs of Durable Medical Equipment.

Benefits are limited to the least expensive Medically Necessary Durable Medical Equipment, Medical Supply, Orthotic Device or Prosthetic adequate to meet the patient's medical needs.

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

11.3 Repairs. Benefits for the repair, maintenance, or replacement of covered Durable Medical Equipment are limited as follows:

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

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

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

11.4 Benefit Limits. Purchase or rental of any Medical Device subject to prior authorization (see Section 11.2) is at the discretion of CareFirst BlueChoice. Benefits for these Medical Devices will be limited to the lower cost of purchase or rental, taking into account the length of time the Member requires, or is reasonably expected to require the equipment, the durability of the equipment, etc. The purchase price or rental cost must be the least expensive of its type adequate to meet the medical needs of the Member. If the Member selects a deluxe version of the appliance, device, or equipment not determined by CareFirst BlueChoice to be Medically Necessary, CareFirst BlueChoice will pay an amount that does not exceed CareFirst BlueChoice's payment for the basic device (minus any Member Deductible, Copayment or Coinsurance) and the Member will be fully responsible for paying the remaining balance.

Benefits for a Medical Device not subject to prior authorization will be limited to the lesser of purchase price of the item or the Allowed Benefit for the least expensive of its type adequate to meet the medical needs of the Member. If the Member selects a deluxe version of the appliance, device, or equipment, CareFirst BlueChoice will pay an amount that does not exceed CareFirst BlueChoice's payment for the basic device (minus the Member Deductible, Copayment or

Coinsurance) and the Member will be fully responsible for paying the remaining balance.

11.5 Responsibility of CareFirst BlueChoice. CareFirst BlueChoice will not be liable for any claim, injury, demand, or judgment based on tort or other grounds (including warranty of equipment), arising out of or in connection with the rental, sale, use, maintenance, or repair of prosthetic devices, corrective appliances or durable medical equipment, whether or not a Covered Service.

SECTION 12
PRESCRIPTION DRUGS

12.1 Covered Services. Except as provided in Section 12.3 below, benefits will be provided for Prescription Drugs, including but not limited to:

A. Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. See Section 1.5C, Contraceptive Methods and Counseling, for additional coverage of contraceptive drugs and devices.

B. Human growth hormones. Prior authorization is required.

C. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preventive Drug List.

Nicotine Replacement Therapy. Nicotine Replacement Therapy means a product, including a product on the Preventive Drug List that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.

D. Injectable medications that are self-administered and the prescribed syringes.

E. Standard covered items such as insulin, glucagon and anaphylaxis kits.

F. Fluoride products.

G. Diabetic Supplies.

H. Infertility drugs or agents, prescribed in connection with, and subject to the limitations of, covered infertility services.

I. Abuse-Deterrent Opioid Analgesic Drug Products.

12.2 Mail Order Program. Except as provided in Section 12.3 below, all Members have the option of ordering Prescription Drugs via mail order. Members ordering Prescription Drugs through the mail order program will be entitled to a thirty (30) day supply for non-Maintenance Drugs and a ninety (90) day supply for Maintenance Drugs.

12.3 Benefits for Specialty Drugs. Benefits will be provided for Specialty Drugs only when obtained from a Pharmacy that is part of the Exclusive Specialty Pharmacy Network.

12.4 Step Therapy or Fail-First Protocol. Prescription Drugs subject to Step Therapy or Fail-First Protocols are listed in the Prescription Guidelines.

CareFirst BlueChoice will not impose a Step Therapy or Fail-First Protocol on a Member if:

A. The Step Therapy Drug has not been approved by the FDA for the medical condition being treated; or,

B. The Member's prescribing provider provides Supporting Medical Information to CareFirst BlueChoice that a covered Prescription Drug:

1. Was ordered for the Member by a prescriber for the Member within the past one hundred eighty (180) days ; and,

2. Based on the professional judgment of the Member's prescribing provider, was effective in treating the Member's disease or medical condition.

SECTION 13
PATIENT-CENTERED MEDICAL HOME

13.1 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, as used in this provision, 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.

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

A. Foster the health care provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;

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

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

Qualifying Individual, as used in this provision, means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst BlueChoice, requiring coordination of health services and who agrees to participate in the PCMH.

13.2 Covered Benefits. Benefits will be provided for the costs associated with the coordination of care for the Qualifying Individual's medical conditions, including:

A. Assess the Qualifying Individual's medical needs;

B. Provide liaison services between the Qualifying Individual and the health care provider(s) and the Care Coordination Team;

C. Create and supervise the Care Plan;

D. Educate the Qualifying Individual and family regarding the Qualifying Individual's disease and self-care techniques;

E. Arrange for consultations with Specialists and other Medically Necessary supplies and services, including community resources, for the Member; and,

F. Assess treatment compliance.

13.3 Limitations. Benefits provided through the Patient-Centered Medical Home Program are available only when provided by a CareFirst BlueChoice-approved health care provider who has elected to participate in the PCMH.

SECTION 14
COMPLEX CHRONIC OR HIGH RISK ACUTE DISEASE MANAGEMENT

14.1 Definitions.

Chronic Care Coordination Program (CCC Program) means the assessment and coordination of primary care services to a Qualified Member with multiple chronic and severe health conditions.

Complex Case Management Program (CCM Program) means the assessment and coordination of specialty services provided to a Qualified Member with advanced or critical illnesses.

Designated Provider means a provider contracted with CareFirst BlueChoice to provide services under CareFirst BlueChoice's Total Care and Cost Improvement Program, which includes the following components: PCMH Program, CCM Program, CCC Program, Comprehensive Medication Review, Enhanced Monitoring Program, Expert Consultation Program, Home-Based Services Program, Hospice and Palliative Care Program, Pharmacy Coordination Program, Substance Abuse and Behavioral Health Program, or other community-based programs outlined in this Section (collectively, the "TCCI Programs") and who has agreed to participate in care coordination activities in cooperation with CareFirst BlueChoice for Qualified Members with complex chronic disease or high risk acute conditions.

Qualified Member means a Member who:

A. Is accepted by CareFirst BlueChoice into one or more of the TCCI Programs described in this Section. CareFirst BlueChoice will consult with the Member's treating physician or nurse practitioner to determine whether the Member has a medical condition that meets the parameters for participation in one or more of the TCCI Programs.

B. Consents to participate and complies with all elements of the TCCI Program(s) in which he/she qualifies including use of a Designated Provider.

C. Continues to meet the criteria for participation in the TCCI Program(s) and participates fully with any applicable plan of care or other requirements, including compliance with direction from a PCP or Specialist while under a plan of care.

D. CareFirst BlueChoice and the Qualified Member's treating physician or nurse practitioner determine is cooperating with, and satisfying the requirements of the TCCI Program(s). CareFirst BlueChoice retains final authority to determine whether a Member is a Qualified Member.

14.2 Benefits and Cost Sharing Waiver.

A. Qualified Members are eligible for a waiver of their cost sharing responsibility for benefits provided under this Section when:

1. While in an active plan of care, the Qualified Member participates in either (a) a CCC Program coordinated by the Qualified Member's PCP who participates in CareFirst BlueChoice's Patient-Centered Medical Home Program or (b) a CCM Program coordinated by the Qualified Member's Specialist, or

2. At CareFirst BlueChoice's initiation, and in consultation with and direction from the Qualified Member's treating provider or nurse practitioner, the Qualified Member participates in one or more of the TCCI Program elements outside of a plan of care and without participating in CCM Program or CCC Program.

B. Qualified Members participating in a CCM Program or CCC Program as set forth in Section 14.2A.1 are eligible for the following CCM Program and CCC Program benefits while in an active plan of care:

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

2. Education of Qualified Member/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 Member's care;

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

6. Identification of and connection to community resources, and other organizations/support services to supplement the Qualified Member's plan of care;

7. Implementation of a plan of care under the direction of the Qualified Member's treating physician or nurse practitioner.

8. Coordination of care, either telephonically or otherwise, between a Designated Provider and a Qualified Member and his/her treating physician.

9. Other Medically Necessary services provided to a Qualified Member while in an active plan of care.

C. Qualified Members participating in a CCM Program or CCC Program while in an active plan of care under Section 14.2A.1 or, pursuant to CareFirst BlueChoice initiation under Section 14.2A.2, are eligible for benefits under following TCCI Program elements:

1. Comprehensive Medication Review (CMR). Benefits will be provided for a pharmacist's review of medications and consultation with the Qualified Member to improve the effectiveness of pharmaceutical therapy.

2. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Member with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Member's chronic condition or disease.

3. Expert Consultation Program (ECP). Benefits will be provided for a review by a team of specialists of a Qualified Member's medical records where the Qualified Member has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

4. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in a home-based care management plan. Covered Services provided to a Qualified Member pursuant to a home-based care management plan under this section will not count toward any visit limits stated in the Schedule of Benefits.

5. Hospice and Palliative Care Program. Benefits will be provided for medical and associated services specifically outlined in a hospice/palliative plan of care.

6. Pharmacy Coordination Program. Benefits will be provided for care coordination services related to a Qualified Member's use of Specialty Drugs.

7. Substance Abuse and Behavioral Health Program. Benefits will be provided for care coordination services related to a Qualified Member's use of mental health and substance abuse services, including behavioral health treatment benefits.

D. Qualified Member Cost Sharing Responsibilities.

1. Under this section, any applicable cost-sharing responsibilities will be waived for (i) TCCI Program services provided by a Designated Provider and (ii) services provided to Qualified Members in an active plan of care.

   Cost-sharing responsibilities are not waived for any (i) prescription or other drug benefits; (ii) services provided in an inpatient institution or facility; or (iii) services provided in a hospital.

2. If the Qualified Member's Agreement is compatible with a federally-qualified Health Savings Account:

   a) If the Qualified Member has funded his/her HSA account during the Benefit Period, then the Qualified Member will be responsible for any associated costs for services under this Section until the annual Deductible has been met, unless the Covered Services appear on the list of preventive services maintained by the Internal Revenue Service.

   b) If the Qualified Member has not funded his/her HSA account during the Benefit Period, then if the Qualified Member agrees not to fund his/her HSA account and provides a signed agreement not to fund his/her HSA account, then the Qualified Member will be eligible for the waiver described in 14.2D.1.

E. Termination.

1. The Qualified Member's participation in the TCCI Program(s) and receipt of benefits and cost-sharing waivers under this Section will be terminated under the following circumstances:

   a) The Qualified Member completes the stated goals of the TCCI Program(s) set forth in the Qualified Member's plan of care and confirmed by the Qualified Member's treating physician or nurse practitioner or, if the TCCI Program(s) benefits are provided to Members not in an active plan of care, when confirmed by the Qualified Member's treating physician or nurse practitioner.

   b) The CareFirst BlueChoice designated nurse, provider, or care coordinator and the Qualified Member's treating physician or nurse practitioner determine that the Qualified Member failed to comply with the TCCI Program(s) and/or any related plan of care or treatment under this Section. The Qualified Member will be given thirty (30) days prior written notice of termination under this subsection.

   c) The Qualified Member's coverage under the Agreement is terminated.

2. If termination is the result of the Qualified Member's failure to comply with the TCCI Program(s) under Section 14.2E.1.(b), the Qualified Member will be provided the opportunity to comply with the TCCI Program(s) during the thirty (30) day notice period. If after consultation between the Qualified Member's

treating physician or nurse practitioner and the CareFirst BlueChoice designated nurse, provider, or care coordinator a determination is made that the Qualified Member is not and will not be compliant with the applicable TCCI Program(s), the Qualified Member will receive a final written notice of termination of benefits under this Section.

3. Upon termination of the Qualified Member's participation in the TCCI Program(s), all cost-sharing waivers and benefits shall be null and void on and after the effective date of the termination of the waiver and the Qualified Member will be responsible for any and all cost-sharing responsibilities as stated in the Schedule of Benefits on and after the date of termination of the waiver.

SECTION 15
GENERAL PROVISIONS

15.1 Referral to a Non-Contracting Specialist or Non-Physician Specialist

A. A Member may request a referral to a Specialist or Non-Physician Specialist who is a Non-Contracting Physician, Non-Contracting Provider or Non-Contracting Vision Provider if:

1. The Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and

a) CareFirst BlueChoice does not contract with a Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or

b) CareFirst BlueChoice cannot provide reasonable access to a Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

2. For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, CareFirst BlueChoice will treat the services received by the Specialist or Non-Physician Specialist as if the service was provided by a Contracting Physician, Contracting Provider or Contracting Vision Provider.

3. A decision by CareFirst BlueChoice not to provide access to or coverage of treatment or health care services by a Specialist or Non-Physician Specialist in accordance with this section constitutes an Adverse Decision as defined in the Agreement.

15.2 Continuing Care with Terminated Providers.

A. When a Contracting Provider terminates its agreement with CareFirst BlueChoice, for any reason except for cause, benefits will be provided for continuing care rendered by the terminated Contracting Provider as described in this section. CareFirst BlueChoice will send a notice to the Member that the Contracting Provider is no longer available.

B. The Member may, upon request, continue to receive Covered Services from his/her Primary Care Physician for up to ninety (90) days after the date of the notice of the Primary Care Physician's termination from CareFirst BlueChoice's provider panel, if termination was for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status. In addition, a Member may continue treatment with a terminated provider if:

1. A Member was in an active course of treatment with the terminated Contracting Provider prior to the date the Member was notified. The Member needs to request, from CareFirst BlueChoice, to continue receiving care from the terminated Contracting Provider. Benefits will be provided for a period of 90 days from the date the Member is notified by CareFirst BlueChoice that the terminated Contracting Provider is no longer available.

2. A Member who has entered her second trimester of pregnancy may continue to receive Covered Services from the terminated Contracting Provider through postpartum care directly related to the delivery.

3. A Member that was terminally ill (as defined by § 1861(dd)(3)(A) of the Social Security Act) at the time the Contracting Provider's agreement terminated may

continue to receive Covered Services directly related to the treatment of the terminal illness until the Member dies.

15.3 Transitioning of Care from Member's Prior Carrier.

A. Prior Authorization. For Members transitioning care from the Member's immediate prior carrier to CareFirst BlueChoice:

1. At the request of the Member, the Member's parent, guardian or designee, or the Member's provider, CareFirst BlueChoice will accept a prior authorization from the Member's prior carrier for the procedures, treatments, medications or services which are Covered Services and Covered Vision Services under this Agreement; and,

2. For the following time periods:

a) the lesser of the course of treatment or ninety (90) days; and,

b) the duration of the three trimesters of pregnancy and the initial postpartum visit.

3. At the expiration of the time periods stated in A.2 of this provision, CareFirst BlueChoice may elect to perform its own utilization review in order to:

a) reassess and make its own determination regarding the need for continued treatment; and

b) authorize any continued procedure, treatment, medication or other Covered Service determined to be Medically Necessary.

4. With respect to services provided through the Maryland Medical Assistance fee-for-service program, this provision will only apply to:

a) Member's transitioning care from the Maryland Medical Assistance Program to CareFirst BlueChoice; and,

b) Behavioral health and dental benefits, to the extent that that they are authorized by a third-party administrator.

B. Continuing Treatment with a Non-Contracting Provider or Non-Participating Dentist initiated while covered by the Member's immediate prior carrier:

1. At the request of the Member, the Member's parent, guardian or designee, or the Member's provider, CareFirst BlueChoice will allow a Member to continue to receive Covered Services rendered by a Non-Contracting Provider or Covered Dental Services from a Non-Participating Dentist at the time of the Member's transition to coverage by CareFirst BlueChoice.

2. Continuing treatment with a Non-Contracting Provider or Non-Participating Dentist pursuant to this provision is limited to:

a) acute conditions;

b) serious chronic conditions;

c) pregnancy;

d) mental health conditions and substance use disorders; and,

e) any other condition on which CareFirst BlueChoice and the Non-Contracting Provider or Non-Participating Dentist reach an agreement on coverage.

f) Examples of the conditions set forth in item B.2.a) and b) include:

(1) bone fractures;

(2) joint replacements;

(3) heart attacks;

(4) cancer;

(5) HIV/AIDS; and,

(6) organ transplants.

3. The Member may continue care with the Non-Contracting Provider or Non-Participating Dentist for the following time periods:

a) the lesser of the course of treatment or ninety (90) days; and,

b) the duration of the three trimesters of pregnancy and the initial postpartum visit.

4. For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, CareFirst BlueChoice will treat the services rendered by the Non-Contracting Provider or Non-Participating Dentist as if the service was provided by a Contracting Provider or Preferred Dentist.

The Member is not responsible for the difference between the Pediatric Dental Allowed Benefit paid to a Preferred Dentist and the charge by a Non-Participating Dentist if the Non-Participating Dentist accepts the Pediatric Dental Allowed Benefit paid to a Preferred Dentist as payment in full or the Non-Participating Dentist agrees to an alternative payment amount from CareFirst BlueChoice.

5. If the Non-Participating Dentist does not accept the Pediatric Dental Allowed Benefit paid to a Preferred Dentist and CareFirst BlueChoice cannot reach an agreement with the Non-Participating Dentist concerning the payment for Covered Dental Services:

a) The Non-Participating Dentist is not required to provide the Covered Dental Services.

b) If the Non-Participating Dentist accepts the Member's assignment of benefits, the Non-Participating Dentist may balance bill the Member for the difference between the Pediatric Dental Allowed Benefit paid to a Preferred Dentist and the charge by the Non-Participating Dentist.

c) Unless the Member has executed an assignment of benefits to the Non-Participating Dentist, CareFirst BlueChoice will facilitate transfer of care of the Member to a Preferred Dentist.

15.4 Limitation on Provider Coverage. Services are covered only if the provider is licensed in the jurisdiction in which the services are rendered and if the services are within the lawful scope of the services for which that provider is licensed. Coverage does not include services rendered to the Member by any individual who is the Member's Spouse, mother, father, daughter, son, brother or sister.

15.5 CareFirst BlueChoice Personnel Availability for Prior Authorization.

CareFirst BlueChoice requires prior authorization for certain medical treatment as stated in this Description of Covered Services. Check the specific description of the Covered Services or Covered Vision Services for a notice regarding prior authorization. Prior authorization will be obtained by Contracting Providers and Contracting Vision Providers on behalf of the Member. CareFirst BlueChoice will have personnel available to provide prior authorization at all times when such prior authorization is required. Prior authorization is not required for services covered by Medicare.

15.6 Pediatric Dental Coverage.

A. The pediatric dental coverage offers the Member a choice of Dentists: Preferred Dentists and Non-Preferred Dentists. Payment depends on the Dentist chosen, as described in the Schedule of Benefits.

B. If a conflict arises regarding the quality and extent of work relating to a Covered Dental Service, the case in question will be submitted to the Dental Plan Dental Director for resolution. See Benefit Determination and Appeal and Grievance Procedures.

C. Benefits for Covered Dental Services rendered by Preferred Dentists will be provided by the Dental Plan as stated in the Schedule of Benefits. Benefits for Covered Dental Services rendered by Participating Dentists and Non-Participating Dentists will be provided by the Dental Plan as stated in the Schedule of Benefits for Non-Preferred Providers. The date a service is received or the date supplies are purchased will be the date such expenses are incurred.

D. Member/Provider Relationship.

1. The Member has the exclusive right to choose a Dentist. Whether a Dentist is a Preferred Dentist or Non-Preferred Dentist relates only to method of payment, and does not imply that any Dentist is more or less qualified than another.

2. The Dental Plan makes payment for Covered Dental Services, but does not provide these services. Neither the Dental Plan nor CareFirst BlueChoice is liable for any act or omission of any Dentist.

E. Referral to a Participating Dental Specialist or Non-Participating Dental Specialist. A Dental Specialist is a Dentist who is certified or trained in a specified field of dentistry. A Member may request a referral to a Dental Specialist who is a Participating Dentist or Non-Participating Dentist if the Member is diagnosed with a condition or disease that requires specialized dental care; and

1. The Dental Plan does not contract with a Preferred Dentist who is a Dental Specialist with the professional training and expertise to treat the condition or disease; or,

2. The Dental Plan cannot provide reasonable access to a Preferred Dentist who is a Dental Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

For purposes of calculating any Coinsurance payable by the Member, the Dental Plan will treat the services rendered by the Participating Dentist who is a Dental Specialist or Non-Participating Dentist who is a Dental Specialist as if the services were provided by a Preferred Dentist who is a Dental Specialist. The Member is not responsible for the difference between the Pediatric Dental Allowed Benefit and the charge by a Non-Participating Dental Specialist to whom the Member has been referred.

A decision by the Dental Plan not to provide access to or coverage of treatment by a Dental Specialist within this section constitutes an Adverse Decision if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

F. Estimate of Eligible Benefits. A Dentist may propose a planned dental treatment or series of dental procedures. A Member may choose to obtain a written estimate of the benefits available for such procedure(s).

The Member is encouraged to obtain a written Estimate of Eligible Benefits (the written estimate of benefits before a service is rendered) also known as a pre-treatment estimate (PTE) for major dental procedures, thereby alerting a Member of the out-of-pocket expenses that may be associated with the treatment plan, related deductibles, co-insurance and/or procedures that are not Covered Dental Services. Based on an Estimate of Eligible Benefits or PTE, a Member can decide whether or not to incur the expense that may be associated with a particular treatment plan.

Failure to obtain an Estimate of Eligible Benefits or PTE has no effect on the benefits to which a Member is entitled under this Agreement, except for orthodontic services. A Member may choose to forgo the Estimate of Eligible Benefits or PTE and proceed with treatment, unless orthodontic services are planned. The process for orthodontic services is described below.

After the services are rendered, the claim will be reviewed by The Dental Plan. Should the review determine that the service(s) rendered met the Dental Plan's criteria for coverage, the benefits will be provided as described herein. However, should the review of the claim determine that the treatment or procedure(s) did not meet the Dental Plan's criteria for coverage, benefits will not be provided.

To request an Estimate of Eligible Benefits or PTE prior to receiving dental treatment or dental procedures, a Member should contact his or her Dentist who will coordinate the request on the Member's behalf. If the Dentist has any questions about the process, he or she may contact the CareFirst BlueChoice Provider Services Department or go to the CareFirst BlueChoice website at www.carefirst.com, which lists information in the Physicians and Providers section, under the subsection for Dental, and list of Resources. The Estimate of Eligible Benefits or PTE is merely an estimate, and it cannot be considered a guarantee of the Member's benefits or enrollment under this Agreement.

The process is different for orthodontic services. The Affordable Care Act requires that orthodontics must be Medically Necessary to be Covered Dental Services. To request a PTE for orthodontic services, the Member must see an orthodontist who will do an exam and orthodontic assessment that may include taking orthodontic records (study models and certain x-rays). The orthodontist will then complete a case assessment using a scoring tool required by the state. Then the orthodontic records and case assessment will be sent to the Dental Plan for evaluation and confirmation of the assessment score. If the score meets or exceeds the baseline requirement, the orthodontics will be approved for the Member. If the score is less than the minimal required score, then the request for orthodontic benefits will be denied.

A decision by the Dental Plan to deny benefits as described in this section constitutes an Adverse Decision as defined in the Agreement if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

15.7 Pediatric and Adult Vision Coverage.

A. When the Member receives a vision examination or Low Vision services from a Contracting Vision Provider, the benefit payment is accepted as payment in full.

B. When a Member receives collection frames and basic spectacle lenses or collection contact lenses from a Contracting Vision Provider, the Member's responsibility is as stated below. The benefit payment is as stated in the attached Schedule of Benefits.

1. When the Member obtains frames from the display of collection frames (the collection designated by the Vision Care Designee) and basic spectacle lenses from a Contracting Vision Provider, the benefit payment is accepted as payment in full. When the Member obtains collection contact lenses (those contact lenses designated by the Vision Care Designee) from a Contracting Vision Provider, the benefit payment is accepted as payment in full.

2. Add-ons to basic spectacle lenses, non-collection frames and non-collection contact lenses are non-Covered Vision Services under this Agreement.

3. Medically Necessary Contact Lenses are covered when obtained from a Contracting Vision Provider.

C. When the Member receives Covered Vision Services from a Non-Contracting Vision Provider, charges above the Vision Allowed Benefit are a non-Covered Vision Service, except where the Member has been referred to the Non-Contracting Vision Provider by CareFirst BlueChoice. Add-ons to basic spectacle lenses are non-Covered Vision Services under this Agreement. The Member is responsible for obtaining prior authorization for Medically Necessary Contact Lenses and Low Vision services by calling the Vision Care Designee at the telephone number on the Member's identification card.

D. Limited Access Area. If the Member resides in an area that does not have adequate access to a Contracting Vision Provider and the Member receives Covered Vision Services from a Non-Contracting Vision Provider, the Vision Care Designee will pay up to 100% of the Vision Allowed Benefit. To determine if the Member resides in a limited access area, the Member must call the Vision Care Designee at the telephone number on the Member's identification card.

E. Benefits for Covered Vision Services rendered by Contracting Vision Providers and Non-Contracting Vision Providers will be provided by CareFirst BlueChoice as stated in the Schedule of Benefits. The date a service is received or the date supplies are purchased will be the date such expenses are incurred.

15.8 Prescription Drug Coverage.

A. Accessing the Prescription Drug Benefit Card Program.

1. Members may use his/her identification card to purchase Prescription Drugs from Contracting Pharmacy Providers. If the Prescription Drug coverage includes a Deductible, the Member must pay the entire cost of the Prescription Drug(s) until the Deductible is satisfied. Once the Deductible, if applicable, has been satisfied, the Member pays the appropriate Copayment or Coinsurance as stated in the Schedule of Benefits.

2. For Prescription Drugs or diabetic supplies purchased from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. In cases of Emergency Services or Urgent Care received outside of the Service Area, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance. In all other cases, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee for the amount up to the Prescription Drug Allowed Benefit, minus any applicable Deductible, or Copayment or Coinsurance. Charges in excess of the Prescription Drug Allowed Benefit are a non-Covered Service.

3. Members have the option of ordering Prescription Drugs via mail order. The mail order program provides its Member's with a Pharmacy that has an agreement with CareFirst BlueChoice or its designee, to provide mail service Prescription Drugs in accordance with the terms of this provision. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance.

B. Additional Terms and Conditions.

1. Members or health care providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Prescription Drug in the Prescription Guidelines. A copy of the Prescription Guidelines is available to the Member or provider upon request.

2. Providers may substitute a Generic Drug for a Brand Name Drug. If there is no Generic Drug for the Brand Name Drug the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits for Preferred Brand Name Drugs or Non-Preferred Brand Name Drugs.

3. If a provider prescribes a non-Preferred Brand Name Drug, and the Member selects the non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the non-Preferred Brand Name Drug Copayment or Coinsurance when Medically Necessary, as determined by CareFirst BlueChoice.

4. Except for a refill of prescription eye drops, Members must use 80% of a dispensed non-Maintenance Drug or Maintenance Drug in the manner prescribed before a refill of that prescription can be obtained.

   Coverage for a refill of prescription eye drops shall be provided in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid Services; and, if:

   a) the prescribing health care practitioner indicates on the original prescription that additional quantities of the prescription eye drops are needed;

   b) the refill requested by the Member does not exceed the number of additional quantities indicated on the original prescription by the prescribing health care practitioner; and,

   c) the prescription eye drops prescribed by the health care practitioner are a covered benefit under the Agreement.

5. The Member is responsible for obtaining prior authorization for Prescription Drugs in the Prescription Guidelines when obtained from a non-Contracting Pharmacy Provider by calling the customer service telephone number listed on the identification card.

SECTION 16
EXCLUSIONS AND LIMITATIONS

The following exclusions apply:

16.1 Services or supplies that are determined by CareFirst BlueChoice to be not Medically Necessary.

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

16.2 Services performed or prescribed under the direction of a person who is not a health care practitioner.

16.3 Services that are beyond the scope of practice of the health care practitioner performing the service.

16.4 Services to the extent they are covered by any governmental unit, except for veterans in Veteran's Administration or armed forces facilities for services received for which the recipient is liable.

16.5 Services or supplies for which the Member is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.

16.6 Except as provided in Section 3 and for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury, the purchase, examination, or fitting of eyeglasses or contact lenses.

16.7 Personal Care services and Domiciliary Care services.

16.8 Services rendered by a health care practitioner who is the Member's spouse, mother, father, daughter, son, brother or sister.

16.9 Experimental/Investigational services.

16.10 Health care practitioner, hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery that involve corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

16.11 Ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.

16.12 Services to reverse a voluntary sterilization procedure.

16.13 Services for sterilization or reverse sterilization for a Dependent minor. This exclusion does not apply to FDA-approved sterilization procedures for women with reproductive capacity.

16.14 Medical or surgical treatment for obesity, unless otherwise specified under Section 1.3G or Section 1.22.

16.15 Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified herein.

16.16 Services incurred before the effective date of the Member's coverage.

16.17 Services incurred after the Member's termination of coverage, not including any services rendered

during any extension of benefits period.

16.18 Surgery or related services for Cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital, or developmental anomalies.

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

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

16.21 Personal hygiene and Convenience Items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.

16.22 Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.

16.23 Inpatient admissions primarily for diagnostic studies, unless authorized by CareFirst BlueChoice.

16.24 The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as provided in Section 11.1D, hearing aids.

16.25 Except for covered ambulance services and travel benefits for a transplant recipient and companion(s) as stated in Section 5.3B, travel, whether or not recommended by a health care practitioner.

16.26 Except for Emergency Services, services received while outside the United States.

16.27 Immunizations related to foreign travel.

16.28 Unless otherwise specified herein, dental work or treatment which includes hospital or professional care in connection with:

A. The operation or treatment for the fitting or wearing of dentures;

B. Orthodontic care or malocclusion;

C. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within six months of the accident; and

D. Dental implants.

16.29 Except for Members under the age of nineteen (19), accidents occurring while and as a result of chewing.

16.30 Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary.

16.31 Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports or exams for his/her prescription or fitting unless these services or supplies are determined to be Medically Necessary.

16.32 Inpatient admissions primarily for physical therapy, unless authorized by CareFirst BlueChoice.

16.33 Benefits will not be provided for Specialty Drugs obtained from a Pharmacy that is not part of the Exclusive Specialty Pharmacy Network.

16.34 Treatment of sexual dysfunction not related to organic disease.

16.35 Services or supplies that duplicate benefits provided under federal, State, or local laws, regulations, or programs.

16.36 Non-human organs and its implantation.

16.37 Non-replacement fees for blood and blood products.

16.38 Lifestyle improvements, nutrition counseling, or physical fitness programs unless included as a Covered Service, Covered Dental Service or Covered Vision Service.

16.39 Wigs or cranial prosthesis, except as provided in Section 11.1F.

16.40 Weekend admission charges, except for Emergency Services and maternity, unless authorized by CareFirst BlueChoice.

16.41 Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.

16.42 Except as provided in Section 2, Pediatric Dental Services, temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.

16.43 Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

16.44 Services for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.

16.45 Services for, or related to, the removal of an organ from a Member for purposes of transplantation into another person unless the transplant recipient is covered under this Agreement and is undergoing a covered transplant, and the services are not payable by another health plan.

16.46 Physical examinations required for obtaining or continuing employment, insurance, or government licensing.

16.47 Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

16.48 Private hospital room, unless authorized by CareFirst BlueChoice.

16.49 Private duty nursing, unless authorized by CareFirst BlueChoice.

16.50 Inpatient and Outpatient Mental Health and Substance Abuse Services. Benefits will not be provided for the following:

A. Services provided by pastoral or marital counselors;

B. Therapy for sexual problems;

C. Treatment for learning disabilities and intellectual disabilities;

D. Telephone therapy;

E. Travel time to the Member's home to conduct therapy;

F. Services rendered or billed by schools, or halfway houses or members of his/her staffs;

G. Marriage counseling.

16.51 Benefits will not be provided for maintenance programs for Cardiac Rehabilitation or pulmonary rehabilitation.

Maintenance programs consist of activities that preserve the Member's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

16.52 Any claim, bill, or other demand or request for payment for health care services determined to be furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.

16.53 Pediatric Dental Services.

A. Limitations.

1. Covered Dental Services must be performed by or under the supervision of a Dentist, within the scope of practice for which licensure or certification has been obtained.

2. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures, including precision attachments and custom denture teeth.

3. If a Member switches from one Dentist to another during a course of treatment, or if more than one Dentist renders services for one dental procedure, the Dental Plan shall pay as if only one Dentist rendered the service.

4. The Dental Plan will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to covered orthodontic services).

5. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative.

6. Benefits for radiographs are limited to radiographs required for proper treatment and/or diagnosis. Benefits for some or multiple radiographs of the same tooth or area may be denied if the Dental Plan determines the number to be redundant, excessive, or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the Pediatric Dental Allowed Benefit for a full month series.

7. When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the Pediatric Dental Allowed Benefit is limited to that of a one-surface restoration. Any charges in excess of the Pediatric Dental Allowed Benefit for the one-surface restoration are not Covered Dental Services.

B. Exclusions. Benefits will not be provided for:

1. Any dental service stated in Section 2 for Members over age nineteen (19). If Member is under age nineteen (19) at the start of the Benefit Period but turns

nineteen (19) during the Benefit Period, then the Member will receive Covered Dental Services through the rest of that Calendar Year.

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

3. Any service, supply, or procedure that is not specifically listed as Covered Dental Services (even if Medically Necessary) or that do not meet all other conditions and criteria for coverage as determined by the Dental Plan.

4. Replacement of a denture or crown as a result of loss or theft.

5. Replacement of an existing denture or crown that is determined by the Dental Plan to be satisfactory or repairable.

6. Replacement of dentures or crowns within sixty (60) months from the date of placement or replacement.

7. Gold foil fillings.

8. Periodontal appliances.

9. Splinting, except for intracoronal and extracoronal splinting.

10. Night guards or other oral orthotic appliances unless specifically listed as a Covered Dental Service.

11. Bacteriologic studies, histopathology exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service.

12. Intentional tooth reimplantation or transplantation, unless specifically listed as a Covered Dental Service and authorized by the Dental Plan.

13. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.

14. Tissue conditioning unless rendered prior to new denture impressions.

15. Additional fees charged for visits by a Dentist to the Member's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. the Dental Plan shall provide the benefits for the dental service as if the visit was rendered in the Dentist’s office during normal office hours.

16. Transseptal fiberotomy.

17. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service.

18. Any orthodontic services after the last day of the month in which Covered Dental Services ended except as specifically stated herein.

19. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be Covered Dental Services).

20. Separate billings for dental care services or supplies furnished by an employee of

a Dentist which are normally included in the Dentist's charges and billed for by them.

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

22. Bridges.

23. Dental implants and all services related to dental implants.

24. Adjustments to dentures made within six (6) months of initial placement.

25. Rebase and/or reline denture within six (6) months of initial placement and limited to one (1) per twenty-four (24) months after the six (6) months following initial placement.

26. A preformed denture with teeth already mounted forming a denture module.

27. Crowns when received within thirty (30) days of the date of service of a root canal or restoration on the same tooth.

28. Extraction of asymptomatic impacted teeth unless removal constitutes the most cost-effective dental procedure for the provision of dentures.

29. Unless otherwise stated in the Description of Covered Services, dentures solely for Cosmetic purposes.

30. Unless otherwise stated in the Description of Covered Services, orthodontic services solely for Cosmetic purposes.

31. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.

16.54 Pediatric Vision Services. Benefits will not be provided for the following:

A. Any pediatric vision service stated in Section 3 for Members over age nineteen (19), except for the vision examination. If the Member is under age nineteen (19) at the start of the Benefit Period but turns nineteen (19) during the Benefit Period, then the Member will receive covered pediatric vision services through the rest of that Calendar Year.

B. Diagnostic services, except as stated in Section 3. Benefits for treatment of medical conditions of the eye are covered under Section 1.

C. Services or supplies not specifically approved by the Vision Care Designee as required for Low Vision Services and Medically Necessary Contact Lenses.

D. Add-ons to basic spectacle lenses. Non-collection frames and non-collection contact lenses are not covered when obtained from a Contracting Vision Provider.

E. Orthoptics, vision training, and low vision aids, except as provided in Section 3.

F. Non-prescription (Plano) lenses and/or glasses, sunglasses or contact lenses.

G. Except as otherwise provided, Vision Care services that are strictly Cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

H. Any vision service, treatment, or materials not specifically listed as a Covered Vision Service.

I. Services and materials not meeting accepted standards of optometric practice.

J. Services and materials resulting from the Member's failure to comply with professionally prescribed treatment.

K. Office infection control charges.

L. Charges for copies of the Member's records, charts, or any costs associated with forwarding or mailing copies of the Member's records or charts.

M. State or territorial taxes on vision services performed.

N. Special lens designs or coatings other than those described herein.

O. Replacement of lost and/or stolen eyewear.

P. Two pairs of eyeglasses in lieu of bifocals.

Q. Insurance of contact lenses.

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An independent licensee of the BlueCross and Blue Shield Association

ATTACHMENT C
SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Agreement.

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

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

DEDUCTIBLE
The Individual Benefit Period Deductible is $3,000. The Family Benefit Period Deductible is $6,000. **Individual Coverage:** The Member must satisfy the Individual Deductible. **Family Coverage:** Each Member can satisfy his/her own Deductible by meeting the Individual Deductible. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Deductible. An individual family Member may not contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible has been met, this will satisfy the Deductible for all covered family Members
The benefit chart below states whether a Covered Service is subject to the Benefit Period Deductible. **The following amounts may <u>not</u> be used to satisfy the Benefit Period Deductible:** • Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available. • Discounts, coupons, or other amounts from third parties, including manufacturer coupons and discount prescription card programs. • Charges in excess of the Allowed Benefit and Prescription Drug Allowed Benefit. • Charges for services which are not covered under the Agreement or which exceed the maximum number of covered visits/days listed below. • Charges for Covered Services not subject to the Deductible. • Charges for Pediatric Vision Services or Pediatric Dental Services.

OUT-OF-POCKET MAXIMUM

The Individual Benefit Period Out-of-Pocket Maximum is $6,650.

The Family Benefit Period Out-of-Pocket Maximum is $13,300.

Individual Coverage: The Member must meet the Individual Out-of-Pocket Maximum.

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

These amounts apply to the Benefit Period Out-of-Pocket Maximum:

- Copayments and Coinsurance for all Covered Services.
- Benefit Period Deductible
- Pediatric Dental Deductible and Coinsurance for Covered Dental Services.

When the Member has reached the Out-of-Pocket Maximum, no further Copayments, Coinsurance or Deductible will be required in that Benefit Period for Covered Services, Covered Dental Services and Covered Vision Services.

The following amounts may <u>not</u> be used to satisfy the Benefit Period Out-of-Pocket Maximum:

- Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.
- Discounts, coupons, or other amounts from third parties, including manufacturer coupons and discount prescription card programs.
- Charges in excess of the Allowed Benefit, Prescription Drug Allowed Benefit, Vision Allowed Benefit and Pediatric Dental Allowed Benefit.
- Charges for services which are not covered under the Agreement or which exceed the maximum number of covered visits/days listed below.

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice. **Prior authorization is required for all outpatient services performed in the outpatient department of a hospital, including but not limited to, outpatient surgery, specialty imaging, diagnostic, laboratory and x-ray services, Outpatient Rehabilitative Services, and Infusion Services. Benefits will not be approved at these locations if CareFirst BlueChoice determines that the procedure can be provided in a medically appropriate manner within a physician's office or other less intensive and less costly setting.** **If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are not covered. Prior authorization is the responsibility of the Contracting Provider and a member cannot be held liable when a Contracting Provider fails to obtain prior authorization.** **Prior authorization is not required for Clinic Visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.** **Except for those services described in the Inter-Plan Arrangement Disclosure or where otherwise authorized by CareFirst BlueChoice, there are NO benefits for services rendered outside the CareFirst BlueChoice Service Area.**			
When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider. The benefit chart below states whether a Covered Service is subject to the Member Copayment or Coinsurance for Clinic Visits/ Outpatient Services rendered in a hospital, hospital clinic, or health care provider's office on a hospital campus ("Clinic Visit"). These providers <u>may</u> bill individually resulting in claims from both the hospital/facility and the physician or health care provider rendering care in the hospital/facility/clinic setting. It is the Member's responsibility to determine whether separate claims will be assessed.			
OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES			
Physician's Office	Services rendered by Specialists in the disciplines listed below will be treated as PCP visits for Member payment purposes. • General internal medicine; • Family practice medicine; • Obstetrician/ Gynecologist; • General pediatric medicine; or • Geriatric medicine.	Yes	PCP: $30 per visit Specialist: $40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Outpatient Non-Surgical Services		Yes	PCP: $30 per visit Specialist: $40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Laboratory Tests, X-Ray/Radiology Services, Specialty Imaging and Diagnostic Procedures			
Non-Preventive Laboratory Tests (independent non-hospital laboratory)		Yes	$25 per visit

BENEFITS			
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Non-Preventive Laboratory Tests (outpatient department of a hospital)	If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.	Yes	$90 per visit
Non-Preventive X-Ray/Radiology Services (independent non-hospital facility)		Yes	$55 per visit
Non-Preventive X-Ray/Radiology Services (outpatient department of a hospital)	If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.	Yes	$130 per visit
Non-Preventive Specialty Imaging (independent non-hospital facility)		Yes	$250 per visit
Non-Preventive Specialty Imaging (outpatient department of a hospital)	If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.	Yes	$500 per visit
Non-Preventive Diagnostic Testing except as otherwise specified (in an independent non-hospital facility)		Yes	$55 per visit
Non-Preventive Diagnostic Testing except as otherwise specified (in an outpatient department of a hospital)	If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.	Yes	$130 per visit

BENEFITS			
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Sleep Studies (Member's home		Yes	$20 per study
Sleep Studies (office or freestanding facility)	Prior authorization is required.	Yes	$100 per study
Sleep Studies (outpatient department of a hospital)	Prior authorization is required.	Yes	$200 per study
Preventive Care – Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society or required by the Patient Protection and Affordable Care Act (PPACA).			
Prostate Cancer Screening		No	No Copayment or Coinsurance
Colorectal Cancer Screening		No	No Copayment or Coinsurance
Breast Cancer Screening		No	No Copayment or Coinsurance
Chlamydia Screening Test		No	No Copayment or Coinsurance
Human Papillomavirus Screening Test		No	No Copayment or Coinsurance
Preventive Laboratory Tests		No	No Copayment or Coinsurance
Preventive X-Ray/Radiology Services		No	No Copayment or Coinsurance
Preventive Specialty Imaging		No	No Copayment or Coinsurance

BENEFITS			
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Preventive Diagnostic Testing (except as otherwise specified)		No	No Copayment or Coinsurance
Immunizations		No	No Copayment or Coinsurance
Well Child Care		No	No Copayment or Coinsurance
Adult Preventive Care		No	No Copayment or Coinsurance
Women's Preventive Services		No	No Copayment or Coinsurance
Osteoporosis Screening		No	No Copayment or Coinsurance
Office Visits for Treatment of Obesity		No	No Copayment or Coinsurance
Professional Nutritional Counseling and Medical Nutrition Therapy		No	No Copayment or Coinsurance
Treatment Services			
Family Planning			
Non-Preventive Gynecological Office Visits		Yes	$30 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Contraceptive Counseling		No	No Copayment or Coinsurance
Contraceptive Drugs and Devices	Coverage of self-administered contraceptive drugs and devices is provided under the Prescription Drugs benefit.	No	No Copayment or Coinsurance

BENEFITS			
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Insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs	Drug or device must be approved by the FDA as a contraceptive.	No	No Copayment or Coinsurance
Elective Sterilization Services – Female Members	Benefits available to female Members with reproductive capacity only.	No	No Copayment or Coinsurance
Elective Sterilization Services – Male Members		Yes	No Copayment or Coinsurance
Maternity and Related Services			
Preventive Visit		No	No Copayment or Coinsurance
Non-Preventive Visit		Yes	$30 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Professional Services for Delivery		Yes	$40 per visit

BENEFITS			
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Infertility Treatment			
Infertility Counseling and Testing		Yes	$30 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Artificial & Intrauterine Insemination	Prior authorization is required.	Yes	$30 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
In Vitro Fertilization	Limited to 3 attempts per live birth. Prior authorization is required.	Yes	$30 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Allergy Services			
Allergy Testing and Allergy Treatment		Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Allergy Shots		Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic

BENEFITS			
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Rehabilitation Services			
Rehabilitative Physical Therapy	Limited to 30 visits per condition per Benefit Period. This limitation does not apply to Habilitative services for Children or Adults. If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.	Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Rehabilitative Occupational Therapy	Limited to 30 visits per condition per Benefit Period. This limitation does not apply to Habilitative services for Children or Adults. If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.	Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice. **Prior authorization is required for all outpatient services performed in the outpatient department of a hospital, including but not limited to, outpatient surgery, specialty imaging, diagnostic, laboratory and x-ray services, Outpatient Rehabilitative Services, and Infusion Services. Benefits will not be approved at these locations if CareFirst BlueChoice determines that the procedure can be provided in a medically appropriate manner within a physician's office or other less intensive and less costly setting.** **If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are not covered. Prior authorization is the responsibility of the Contracting Provider and a member cannot be held liable when a Contracting Provider fails to obtain prior authorization.** **Prior authorization is not required for Clinic Visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.** **Except for those services described in the Inter-Plan Arrangement Disclosure or where otherwise authorized by CareFirst BlueChoice, there are NO benefits for services rendered outside the CareFirst BlueChoice Service Area.**			
Rehabilitative Speech Therapy	Limited to 30 visits per condition per Benefit Period. This limitation does not apply to services for cleft lip and cleft palate or Habilitative services for Children or Adults. If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.	Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Chiropractic Services	Limited to 20 visits per condition per Benefit Period.	Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Habilitative Services for Children	Limited to Members until the end of the month in which the Member turns 19 years old. Prior authorization is required for Habilitative Services.	Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Habilitative Services for Adults	Benefits are available to Members on the first day of the month after the Member turns age 19. Limited to 30 visits per condition per Benefit Period for Physical Therapy, 30 visits per condition per Benefit Period for Occupational Therapy and 30 visits per condition per Benefit Period for Speech Therapy Prior authorization is required for Habilitative services for Adults.	Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic

BENEFITS			
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Acupuncture		Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Cardiac Rehabilitation	Limited to 90 visits per therapy per Benefit Period.	Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Pulmonary Rehabilitation	Limited to one pulmonary rehabilitation program per lifetime.	Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Other Treatment Services			
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation, pulmonary rehabilitation and Infusion Services)	If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.	Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Infusion Therapy			
Physician's Office	Prior authorization is required for Covered Specialty Drugs in the Prescription Guidelines.	Yes	$20 per session
Free-Standing Infusion Center	Prior authorization is required for Covered Specialty Drugs in the Prescription Guidelines.	Yes	$20 per session
Hospital Outpatient Department	Prior authorization is required for Covered Specialty Drugs in the Prescription Guidelines.	Yes	$200 per session

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Member's Home	Prior authorization is required for Covered Specialty Drugs in the Prescription Guidelines.	Yes	$20 per session
Blood and Blood Products		Benefits are available to the same extent as benefits provided for other infusion services	
Controlled Clinical Trial	Prior authorization is required.	Benefits are available to the same extent as benefits provided for other services	
General Anesthesia for Dental Care	Prior authorization is required.	Benefits are available to the same extent as benefits provided for other services	
Accidental Dental Injury Services	Benefits are available to the same extent as benefits provided for other services		
Services for the Treatment of Cleft Lip, Cleft Palate or Both	Benefits are available to the same extent as benefits provided for other services		
Retail Health Clinic		Yes	$30 per visit
Telemedicine Services	Benefits are available to the same extent as benefits provided for other services		
Outpatient Surgical Facility and Professional Services			
Surgical Care at an Ambulatory Care Facility		Yes	$300 per visit
Outpatient Surgical Professional Services Provided at an Ambulatory Care Facility	Routine/Screening Colonoscopy is <u>not</u> subject to the Copayment and Deductible.	Yes	$40 per visit
Surgical Care at an Outpatient Hospital Facility	If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.	Yes	$450 per visit

BENEFITS			
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Outpatient Surgical Professional Services Provided at an Outpatient Hospital	Routine/Screening Colonoscopy is not subject to the Copayment and Deductible. If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are a non-Covered Service.	Yes	$40 per visit
INPATIENT HOSPITAL SERVICES			
Inpatient Facility (medical or surgical condition, including maternity and rehabilitation)	Prior authorization is required except for emergency admissions and all maternity admissions.	Yes	$500 per day up to a Member maximum payment of $2,500 per admission
Inpatient Professional Services		Yes	$40 per visit
Organ and Tissue Transplants	Except for corneal transplants and kidney transplants, prior authorization is required.	Benefits are available to the same extent as benefits provided for other services	
SKILLED NURSING FACILITY SERVICES			
Skilled Nursing Facility Services	Limited to 100 days per Benefit Period. Prior authorization is required.	Yes	$100 per admission
HOME HEALTH SERVICES			
Home Health Services	Prior authorization is required.	Yes	No Copayment or Coinsurance
Postpartum Home Visits	Benefits are available to all Members.	Yes	No Copayment or Coinsurance
Home Visits Following a Mastectomy and Surgical Removal of a Testicle		Yes	No Copayment or Coinsurance

BENEFITS			
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HOSPICE SERVICES			
Inpatient Care	Prior authorization is required.	Yes	No Copayment or Coinsurance
Outpatient Care	Prior authorization is required.	Yes	No Copayment or Coinsurance
Respite Care	Prior authorization is required.	Yes	No Copayment or Coinsurance
Bereavement Services	Prior authorization is required.	Yes	No Copayment or Coinsurance
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES			
Outpatient Services			
Office Visits		Yes	$30 per visit
Outpatient Hospital Facility Services		Yes	$55 per visit
Outpatient Professional Services Provided at an Outpatient Hospital Facility		Yes	$40 per visit
Outpatient Psychological and Neuro-psychological Testing for Diagnostic Purposes		Yes	No Copayment or Coinsurance
Methadone Maintenance		Yes	No Copayment or Coinsurance
Partial Hospitalization		Yes	$55 per visit
Professional Services at a Partial Hospitalization Facility		Yes	$40 per visit

BENEFITS			
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Inpatient Services			
Inpatient Facility Services	Prior authorization is required except for emergency admissions.	Yes	$500 per day up to a Member maximum payment of $2,500 per admission
Inpatient Professional Services		Yes	$40 per visit
Inpatient Residential Treatment Center Services			
Inpatient Residential Treatment Center Facility Services	Prior authorization is required except for emergency admissions.	Yes	$500 per day up to a Member maximum payment of $2,500 per admission
Inpatient Residential Treatment Center Professional Services		Yes	$40 per visit
EMERGENCY SERVICES AND URGENT CARE			
Urgent Care Facility	Limited to unexpected, urgently required services.	Yes	**Inside the CareFirst BlueChoice Service Area**: $60 per visit **Outside the CareFirst BlueChoice Service Area**: $60 per visit for service rendered by another Blue Cross and Blue Shield Plan's contracted provider $60 per visit for services rendered by a non-contracted provider of another Blue Cross and Blue Shield Plan and the Member may be responsible for the difference between the Allowed Benefit and the non-contracted provider's billed charges

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
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Hospital Emergency Room - Facility Services	Limited to Emergency Services or unexpected, urgently required services.	Yes	**Inside the CareFirst BlueChoice Service Area**: $300 per visit (waived if admitted) **Outside the CareFirst BlueChoice Service Area**: $300 per visit for service rendered by another Blue Cross and Blue Shield Plan's contracted provider (waived if admitted) $300 per visit (waived if admitted) for services rendered by a non-contracted provider of another Blue Cross and Blue Shield Plan and the Member may be responsible for the difference between the Allowed Benefit and the non-contracted provider's billed charges

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice. **Prior authorization is required for all outpatient services performed in the outpatient department of a hospital, including but not limited to, outpatient surgery, specialty imaging, diagnostic, laboratory and x-ray services, Outpatient Rehabilitative Services, and Infusion Services. Benefits will not be approved at these locations if CareFirst BlueChoice determines that the procedure can be provided in a medically appropriate manner within a physician's office or other less intensive and less costly setting.** **If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are not covered. Prior authorization is the responsibility of the Contracting Provider and a member cannot be held liable when a Contracting Provider fails to obtain prior authorization.** **Prior authorization is not required for Clinic Visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.** **Except for those services described in the Inter-Plan Arrangement Disclosure or where otherwise authorized by CareFirst BlueChoice, there are NO benefits for services rendered outside the CareFirst BlueChoice Service Area.**			
Hospital Emergency Room – Professional Services	Limited to Emergency Services or unexpected, urgently required services.	Yes	**Inside the CareFirst BlueChoice Service Area**: $40 per visit **Outside the CareFirst BlueChoice Service Area**: $40 per visit for service rendered by another Blue Cross and Blue Shield Plan's contracted provider $40 per visit for services rendered by a non-contracted provider of another Blue Cross and Blue Shield Plan and the Member may be responsible for the difference between the Allowed Benefit and the non-contracted provider's billed charges

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice. **Prior authorization is required for all outpatient services performed in the outpatient department of a hospital, including but not limited to, outpatient surgery, specialty imaging, diagnostic, laboratory and x-ray services, Outpatient Rehabilitative Services, and Infusion Services. Benefits will not be approved at these locations if CareFirst BlueChoice determines that the procedure can be provided in a medically appropriate manner within a physician's office or other less intensive and less costly setting.** **If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are not covered. Prior authorization is the responsibility of the Contracting Provider and a member cannot be held liable when a Contracting Provider fails to obtain prior authorization.** **Prior authorization is not required for Clinic Visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.** **Except for those services described in the Inter-Plan Arrangement Disclosure or where otherwise authorized by CareFirst BlueChoice, there are NO benefits for services rendered outside the CareFirst BlueChoice Service Area.**			
Office Visits for Follow-Up Care after Emergency Surgery	Limited to Emergency Services or unexpected, urgently required services.	Yes	**Inside the CareFirst BlueChoice Service Area**: $40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic **Outside the CareFirst BlueChoice Service Area**: $40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic for service rendered by another Blue Cross and Blue Shield Plan's contracted provider $40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic for services rendered by a non-contracted provider of another Blue Cross and Blue Shield Plan and the Member may be responsible for the difference between the Allowed Benefit and the non-contracted provider's billed charges

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice. **Prior authorization is required for all outpatient services performed in the outpatient department of a hospital, including but not limited to, outpatient surgery, specialty imaging, diagnostic, laboratory and x-ray services, Outpatient Rehabilitative Services, and Infusion Services. Benefits will not be approved at these locations if CareFirst BlueChoice determines that the procedure can be provided in a medically appropriate manner within a physician's office or other less intensive and less costly setting.** **If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are not covered. Prior authorization is the responsibility of the Contracting Provider and a member cannot be held liable when a Contracting Provider fails to obtain prior authorization.** **Prior authorization is not required for Clinic Visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.** **Except for those services described in the Inter-Plan Arrangement Disclosure or where otherwise authorized by CareFirst BlueChoice, there are NO benefits for services rendered outside the CareFirst BlueChoice Service Area.**			
Emergency Ambulance Service	Limited to Emergency Services or unexpected, urgently required services.	Yes	**Inside the CareFirst BlueChoice Service Area**: $40 per visit **Outside the CareFirst BlueChoice Service Area**: $40 per visit for service rendered by another Blue Cross and Blue Shield Plan's contracted provider $40 per visit for services rendered by a non-contracted provider of another Blue Cross and Blue Shield Plan and the Member may be responsible for the difference between the Allowed Benefit and the non-contracted provider's billed charges
Non-Emergency Ambulance Services	Prior authorization is required for air ambulance services	Yes	**Inside the CareFirst BlueChoice Service Area**: $40 per visit **Outside the CareFirst BlueChoice Service Area**: $40 per visit for service rendered by another Blue Cross and Blue Shield Plan's contracted provider $40 per visit for services rendered by a non-contracted provider of another Blue Cross and Blue Shield Plan and the Member may be responsible for the difference between the Allowed Benefit and the non-contracted provider's billed charges

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice. **Prior authorization is required for all outpatient services performed in the outpatient department of a hospital, including but not limited to, outpatient surgery, specialty imaging, diagnostic, laboratory and x-ray services, Outpatient Rehabilitative Services, and Infusion Services. Benefits will not be approved at these locations if CareFirst BlueChoice determines that the procedure can be provided in a medically appropriate manner within a physician's office or other less intensive and less costly setting.** **If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are not covered. Prior authorization is the responsibility of the Contracting Provider and a member cannot be held liable when a Contracting Provider fails to obtain prior authorization.** **Prior authorization is not required for Clinic Visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.** **Except for those services described in the Inter-Plan Arrangement Disclosure or where otherwise authorized by CareFirst BlueChoice, there are NO benefits for services rendered outside the CareFirst BlueChoice Service Area.**			
MEDICAL DEVICES AND SUPPLIES			
Durable Medical Equipment	Prior authorization is required for the Covered Services listed in Section 11.2 of the Description of Covered Services.	Yes	20% of the Allowed Benefit
Orthotic and Prosthetic Devices	Prior authorization is required for the Covered Services listed in Section 11.2 of the Description of Covered Services.	Yes	20% of the Allowed Benefit
Hair Prosthesis	Limited to one per Benefit Period.	Yes	20% of the Allowed Benefit
Medical Food for Members with Metabolic Disorders		Yes	20% of the Allowed Benefit
Breastfeeding Equipment and Supplies		No	No Copayment or Coinsurance
Diabetes Equipment		Yes	20% of the Allowed Benefit
Diabetic Supplies	Coverage for Diabetes Supplies is also provided under the Prescription Drug benefit.	Yes	No Copayment or Coinsurance
Hearing Aids			
Hearing Aids	Limited to one hearing aid for each hearing-impaired ear every 36 months.	Yes	20% of the Allowed Benefit
Hearing Aid Related Services		Yes	$40 per visit **and** $100 per visit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
WELLNESS BENEFIT			
Health Risk Assessment		No	No Copayment or Coinsurance
Health Risk Assessment Feedback		No	No Copayment or Coinsurance

BENEFITS			
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**MEMBER PAYS**
Covered Services, Covered Vision Services and Covered Dental Services must be Medically Necessary as determined by CareFirst BlueChoice. **Prior authorization is required for all outpatient services performed in the outpatient department of a hospital, including but not limited to, outpatient surgery, specialty imaging, diagnostic, laboratory and x-ray services, Outpatient Rehabilitative Services, and Infusion Services. Benefits will not be approved at these locations if CareFirst BlueChoice determines that the procedure can be provided in a medically appropriate manner within a physician's office or other less intensive and less costly setting.** **If prior authorization is not obtained, benefits for outpatient services performed in the outpatient department of a hospital are not covered. Prior authorization is the responsibility of the Contracting Provider and a member cannot be held liable when a Contracting Provider fails to obtain prior authorization.** **Prior authorization is not required for Clinic Visits rendered in a hospital, hospital clinic or health care provider's office on a hospital campus.** **Except for those services described in the Inter-Plan Arrangement Disclosure or where otherwise authorized by CareFirst BlueChoice, there are NO benefits for services rendered outside the CareFirst BlueChoice Service Area.**			
TOTAL CARE AND COST IMPROVEMENT, HEALTH PROMOTION, WELLNESS AND DISEASE MANAGEMENT			
Associated Costs for the Patient-Centered Medical Home Program (PCMH)	Benefits will be provided as described in the Description of Covered Services for Patient-Centered Medical Home.	Yes	No Copayment or Coinsurance
TCCI Program Elements	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment.	No, unless the Member has made contributions to an HSA during the Benefit Period.	No Copayment or Coinsurance
Services Provided Pursuant to an Active Plan of Care under the BHCC Program, CCC Program, or SUD Program	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment. Members may simultaneously participate in the CCC Program and either the SUD Program or the BHCC Program, but no Member may simultaneously participate in all three Programs.	No, unless the Member has made contributions to an HSA during the Benefit Period.	No Copayment or Coinsurance
Health Promotion and Wellness	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment.	No	No Copayment or Coinsurance
Disease Management	Benefits will be provided as described in the Total Care and Cost Improvement, Health Promotion, Wellness and Disease Management Program Amendment.	No	No Copayment or Coinsurance

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• Except for Emergency Services and Urgent Care outside the Service Area, when Covered Prescription Drugs are purchased from a non-Contracting Pharmacy Provider, charges above the Prescription Drug Allowed Benefit are a non-Covered Service. • If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice. • Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Deductible stated in this Schedule of Benefits. • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines.				
Contraceptive Drugs	Limited to a single dispensing of a six (6) month supply except as provided in Section 12.2C.2 in the Description of Covered Services. To receive a Brand Name Contraceptive Drug at no cost share when there is a Generic Drug available, prior authorization is required. Without prior authorization, the Member will be responsible for two times the applicable cost share for a Maintenance Drug.	No	No Copayment or Coinsurance when contraceptive drug or device that is approved by the FDA and is obtained under a written prescription. A contraceptive drug or device that is approved by the FDA and obtained without a written prescription will not be subject to a Copayment or Coinsurance if the contraceptive drug or device is purchased from a Contracting Pharmacy.	
Covered Prescription Drugs	Limited to a 30-day supply per prescription or refill.	Preventive Drugs: No Diabetic Supplies, oral chemotherapy, Generic Drug, Preferred Brand Name Drug and Non-Preferred Brand Name Drug: Yes	**Preventive Drugs, Diabetic Supplies and Oral Chemotherapy Drugs:** No Copayment or Coinsurance **Generic Drugs:** $10 per prescription or refill **Preferred Brand Name Drugs:** $50 per prescription or refill **Non-Preferred Brand Name Drugs:** $70 per prescription or refill	

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• Except for Emergency Services and Urgent Care outside the Service Area, when Covered Prescription Drugs are purchased from a non-Contracting Pharmacy Provider, charges above the Prescription Drug Allowed Benefit are a non-Covered Service. • If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in this Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice. • Except as otherwise provided, Covered Services rendered by Contracting Pharmacy Providers and Non-Contracting Pharmacy Providers are subject to the Deductible stated in this Schedule of Benefits. • The Member shall pay the lesser of the cost of the prescription or the applicable Copayment. • Prior authorization is required for human growth hormones and all Prescription Drugs contained in the Prescription Guidelines.				
Maintenance Drugs	Limited to a 90-day supply per prescription or refill. Maintenance Drug means a Covered Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.	Preventive Drugs: No Diabetic Supplies, oral chemotherapy, Generic Drug, Preferred Brand Name Drug and Non-Preferred Brand Name Drug: Yes	**Preventive Drugs, Diabetic Supplies and Oral Chemotherapy Drugs:** No Copayment or Coinsurance **Generic Drugs:** $20 per prescription or refill **Preferred Brand Name Drugs:** $100 per prescription or refill **Non-Preferred Brand Name Drugs:** $140 per prescription or refill	
Covered Specialty Drugs	Benefits for Covered Specialty Drugs are only available when Covered Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network. Coverage for Specialty Drugs will **not** be provided when a Member purchases Covered Specialty Drugs from a Pharmacy **outside** of the Exclusive Specialty Pharmacy Network.	Yes	**Preferred Specialty Drugs:** $100 per prescription or refill for up to a 30-day supply of a non-Maintenance Drug $200 per prescription or refill for up to a 90-day supply of a Maintenance Drug **Non-Preferred Specialty Drugs:** $150 per prescription or refill for up to a 30-day supply of a non-Maintenance Drug $300 per prescription or refill for up to a 90-day supply of a Maintenance Drug	

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.				
			MEMBER PAYS	
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**CONTRACTING VISION PROVIDER**	**NON-CONTRACTING VISION PROVIDER**
Eye Examination	Limited to one per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $40 are a non-Covered Vision Service.
Lenses - Important note regarding Member Payments: "Basic" means spectacle lenses with no "add-ons" such as, glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses and others which may result in additional costs to the Member.				
Basic Single vision	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $40 are a non-Covered Vision Service.
Basic Bifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $60 are a non-Covered Vision Service.
Basic Trifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $80 are a non-Covered Vision Service.
Basic Lenticular	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $100 are a non-Covered Vision Service.
Frames				
Frames	Limited to one frame per Benefit Period. Services rendered by Contracting Vision Providers limited to frames contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $70 are a non-Covered Vision Service.
Low Vision				
Low Vision Eye Examination	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider Limited to one comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $300 are a non-Covered Vision Service.

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.				
			MEMBER PAYS	
SERVICE	**LIMITATIONS**	**SUBJECT TO DEDUCTIBLE?**	**CONTRACTING VISION PROVIDER**	**NON-CONTRACTING VISION PROVIDER**
Follow-up care	Prior authorization required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider Limited to four visits in any five-year period.	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $100 are a non-Covered Vision Service.
High-power Spectacles, Magnifiers and Telescopes	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider	No	No Copayment or Coinsurance.	Expenses in excess of the Vision Allowed Benefit of $600 are a non-Covered Vision Service.
Contact Lenses				
Elective	Includes evaluation, fitting and follow-up fees. Limited to one pair per Benefit Period or multiple pairs of disposable contact lenses per Benefit Period. Services rendered by Contracting Vision Providers limited to contact lenses contained in the Vision Care Designee's collection.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $105 are a non-Covered Service.

Pediatric Vision – Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services up to the end of the Calendar Year in which the Member turns age 19.				
			MEMBER PAYS	
SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	CONTRACTING VISION PROVIDER	NON-CONTRACTING VISION PROVIDER
Medically Necessary	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $225 are a non-Covered Service.

Adult Vision – For Members age 19 and older				
			MEMBER PAYS	
SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	CONTRACTING VISION PROVIDER	NON-CONTRACTING VISION PROVIDER
Eye Examination	Limited to one per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $40 are a non-Covered Vision Service.
Spectacle Lenses - Important note regarding Member Payments: The Member payment is zero for "Basic" single vision, bifocal, double bifocal, trifocal and lenticular spectacle lenses when lenses are provided by a Contracting Vision Provider; otherwise the Member payment is the expense of any add-ons requested. "Basic" means spectacle lenses with no "add-ons" such as scratch-resistant coating, glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses and others.				
Basic Single Vision	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $52 are a non-Covered Vision Service.
Basic Bifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $82 are a non-Covered Vision Service.
Basic Double Bifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $82 are a non-Covered Vision Service.
Basic Trifocals	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $101 are a non-Covered Vision Service.
Basic Lenticular	Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $181 are a non-Covered Vision Service.

Adult Vision – For Members age 19 and older				
			MEMBER PAYS	
SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	CONTRACTING VISION PROVIDER	NON-CONTRACTING VISION PROVIDER
Frames				
Frames chosen from the Vision Care Designee's collection	Limited to one frame per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $70 are a non-Covered Vision Service.
Frames not chosen from the Vision Care Designee's collection		No	Expenses in excess of the Vision Allowed Benefit of $70 are a non-Covered Vision Service.	Expenses in excess of the Vision Allowed Benefit of $70 are a non-Covered Vision Service.
Contact Lenses - Important note regarding Member Payments: The Member payment is zero for select elective contact lenses contained in the Vision Care Designee's collection and provided by a Contracting Vision Provider; otherwise, the Member payment is the expenses in excess of the Vision Allowed Benefit.				
Elective contact lenses (in place of frames and spectacle lenses)				
Select Single Vision elective, including disposable contact lenses	Limited to one pair per Benefit Period or multiple pairs of disposable contact lenses per Benefit Period. Coverage is not provided for evaluation, fitting and follow-up fees.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $105 are a non-Covered Service.
Any other Single Vision elective, including disposable contact lenses		No	Expenses in excess of the Vision Allowed Benefit of $105 are a non-Covered Service.	Expenses in excess of the Vision Allowed Benefit of $105 are a non-Covered Service.
Select Bifocal elective, including disposable contact lenses	Limited to one pair per Benefit Period or multiple pairs of disposable contact lenses per Benefit Period. Coverage is not provided for evaluation, fitting and follow-up fees.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $127 are a non-Covered Service.
Any other Bifocal elective, including disposable contact lenses		No	Expenses in excess of the Vision Allowed Benefit of $127 are a non-Covered Service.	Expenses in excess of the Vision Allowed Benefit of $127 are a non-Covered Service.
Medically Necessary	Prior authorization is required. It is the Member's responsibility to obtain prior authorization for services obtained from a Non-Contracting Vision Provider Limited to one pair per Benefit Period.	No	No Copayment or Coinsurance	Expenses in excess of the Vision Allowed Benefit of $285 are a non-Covered Service.

Pediatric Dental – Limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Dental Services up to the end of the Calendar Year in which the Member turns age 19.	
Pediatric Dental Deductible	
The In-Network Deductible of $25 per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services.	The Out-of-Network Deductible of $50 per Member per Benefit Period applies to all Class II, III, and IV Covered Dental Services.
Pediatric Dental Out-of-Pocket Maximum	
Amounts paid by the Member for Covered Pediatric Dental Services will be applied to the Out-of-Pocket Maximum stated in this Schedule of Benefits. Once the Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible or Coinsurance.	

SERVICE	LIMITATIONS	SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED DENTIST	NON-PREFERRED DENTIST
Class I Preventive & Diagnostic Services		No	No Coinsurance	20% of the Pediatric Dental Allowed Benefit
Class II Basic Services		Yes	20% of the Pediatric Dental Allowed Benefit	40% of the Pediatric Dental Allowed Benefit
Class III Major Services – Surgical		Yes	20% of the Pediatric Dental Allowed Benefit	40% of the Pediatric Dental Allowed Benefit
Class IV Major Services – Restorative		Yes	50% of the Pediatric Dental Allowed Benefit	65% of the Pediatric Dental Allowed Benefit
Class V Orthodontic Services	Limited to Members with severe, dysfunctional, handicapping malocclusion. A pre-treatment estimate (PTE) must be submitted to CareFirst BlueChoice, and CareFirst BlueChoice must approve the services. It is the Member's responsibility to obtain the pre-treatment estimate (PTE).	No	50% of the Pediatric Dental Allowed Benefit	65% of the Pediatric Dental Allowed Benefit

CareFirst BlueChoice, Inc.

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

INTER-PLAN ARRANGEMENTS DISCLOSURE AMENDMENT

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

Out-of-Area Services

CareFirst BlueChoice has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever Members obtain healthcare services outside of the CareFirst BlueChoice Service Area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside the CareFirst BlueChoice Service Area, Members will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") 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 healthcare providers. CareFirst BlueChoice payment practices in both instances are described below.

CareFirst BlueChoice covers only limited healthcare services received outside of its Service Area. As used in this amendment "Out-of-Area Covered Healthcare Services" means:

1. Emergency Services;
2. Urgent Care;
3. Follow-up care after emergency surgery for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's Primary Care Physician;

obtained outside the geographic area CareFirst BlueChoice serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements.

A. BlueCard® Program

Under the BlueCard® Program, when Members obtain Out-of-Area Covered Healthcare Services from a contracted provider within the geographic area served by a Host Blue, CareFirst BlueChoice will remain responsible for fulfilling its contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables Members to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to the Member, so there are no claim forms for the Member to fill out. Members will be responsible for the Member payment amount, as stated in the Agreement.

Emergency Care Services: A Member requiring Emergency Services while traveling outside the CareFirst BlueChoice Service Area should go to the nearest emergency or Urgent Care facility.

Whenever a Member accesses Out-of-Area Covered Healthcare Services and the claim is processed through the BlueCard Program, the amount the Member pays for Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

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

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

Estimated pricing and average pricing, 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 BlueChoice uses for a claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, CareFirst BlueChoice would then calculate Member liability for any Out-of-Area Covered Healthcare Services according to the statutes of the State of Maryland.

B. Non-Participating Healthcare Providers Outside the CareFirst BlueChoice Service Area

Member Liability Calculation: When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount the Member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by the statutes of the State of Maryland. In any case, the Member will only be liable for any Deductible or Copayment for the Out-of-Area Covered Healthcare Services as set forth in the Agreement.

This amendment is subject to all of the terms and conditions of the Agreement to which it is attached and does not change any terms or conditions, except as specifically stated herein.

CareFirst BlueChoice, Inc.

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

2019 AMENDMENT

This amendment is effective _____. If no date is shown, this amendment is effective on the effective date or renewal date of the Individual Enrollment Agreement to which this amendment is attached.

TABLE OF CONTENTS

The Agreement is amended as follows:

SECTION A – DEFINITIONS

1. The definition of "Contracting Pharmacy Provider" in Section 1 of the Individual Enrollment Agreement is deleted and replaced with the following:

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

2. The definition of "Preferred Drug List" in Section 1 of the Individual Enrollment Agreement is deleted and replaced with the following:

   Preferred Drug List means the list of Preferred Drugs issued by CareFirst BlueChoice and used by health care providers when writing, and Pharmacists, when filling, prescriptions. All Generic Drugs are included in the Preferred Drug List. Not all Brand Name Drugs listed in the Formulary are included in the Preferred Drug List. CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Preferred Drug List is available to the Member upon request.

3. The definition of "Prescription Drug" in Section 1 of the Individual Enrollment Agreement is deleted and replaced with the following:

   Prescription Drug means

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

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

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

D. Diabetic Supply.

E. Prescription Drugs do not include:

1. Compounded bulk powders that contain ingredients that:

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

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

c) Do not require a prescription to be dispensed.

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

a) There is no commercially available bio-equivalent Prescription Drug; OR

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

4. The definition of "Prescription Guidelines" in Section 1 of the Individual Enrollment Agreement is deleted and replaced with the following:

Prescription Guidelines means the limited list of Prescription Drugs issued by CareFirst BlueChoice for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from CareFirst BlueChoice, the quantity limits the CareFirst BlueChoice has placed on certain drugs and Prescription Drugs which require Step Therapy. CareFirst BlueChoice may change the requirements contained in the guidelines periodically without notice to Members. A copy of the Prescription Guidelines is available to the Member upon request.

5. The following definitions are added to Section 1 of the Individual Enrollment Agreement:

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

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

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

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

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

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

Substance Use Disorder means:

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

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

SECTION B – SPECIAL ENROLLMENT PERIODS

1. The opening paragraph to Section 2.6B in the Individual Enrollment Agreement is deleted and replaced with the following:

B. Special Enrollment. If a Qualified Individual does not enroll during an Annual Open Enrollment Period, he or she may only enroll through the Exchange during a Special Enrollment Period.

Except as otherwise provided, during a Special Enrollment Period, a Qualified Individual not currently enrolled in a QHP may enroll in any QHP. In addition, a Qualified Individual and his or her Dependents currently enrolled a QHP may enroll in another QHP within the same metal level of coverage, or one metal level higher or lower if the same metal level of coverage is not available.

If a Dependent qualifies for a Special Enrollment Period, and the Subscriber is adding the Dependent to his or her QHP, the Subscriber may add the Dependent to his or her current QHP; or, if the QHP's business rules do not allow the Dependent to enroll, the Subscriber and his or her dependents may change to another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available), or the Dependent may enroll as a new Qualified Individual in a separate QHP.

These limitations do not apply to Section 2.6B.1.(i) (plan enrollment for Indians), Section 2.6B.1.(d) (Exchange errors or non-Exchange errors), Section 2.6B.1.(j) (exceptional circumstances), Section 2.6B.1.(m) (victim of domestic abuse or spousal abandonment) and 2.6B.1(o) (material plan errors). For Qualified Individuals using a Special Enrollment Period pursuant to Section 2.6B.1.(i) (plan enrollment for Indians), Section 2.6B.1.(d) (Exchange errors or non-Exchange errors), Section 2.6B.1.(j) (exceptional circumstances), Section 2.6B.1.(m) (victim of domestic abuse or spousal abandonment) and Section 2.6B.1(o) (adequate demonstration to the Exchange that a material error related to plan benefits, Service Area, or Premium influenced the eligible individual's decision to purchase a QHP through the Exchange), the Qualified Individual or the Dependent of a Qualified Individual may enroll in or change to any QHP regardless of whether the Qualified Individual or Dependent of a Qualified Individual is currently enrolled in a QHP.

2. Section 2.6B.1.a)(3) in the Individual Enrollment Agreement is deleted and replaced with the following:

(3) Loses pregnancy-related coverage described in 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) or loses access to health care services through coverage provided to a pregnant woman's unborn child, based on the definition of a child in 42 CFR 457.10. The date of the loss of coverage is the last day the qualified individual would have pregnancy-related coverage or access to health care services through the unborn child coverage; or

3. Section 2.6B.1.b) in the Individual Enrollment Agreement is deleted and replaced with the following:

b) A Qualified Individual gains, or becomes, a Dependent through marriage, birth, adoption, placement for adoption, grant of court or testamentary guardianship, child support order (MCSO) or other court order, or placement of a child for foster care. The foster child is not eligible for coverage under this Agreement.

Except in the case of gaining or becoming a Dependent through marriage,, if the Qualified Individual and any Dependents are not currently enrolled in a QHP, the Qualified Individual and any Dependents (except for a foster child) may enroll in any QHP. If the Qualified Individual's current QHP does not allow the dependent to enroll in the same QHP, the Qualified Individual and any Dependents can enroll in different QHP of the same metal level or one metal level higher or lower.

In the case of marriage, at least one Spouse must demonstrate that he or she:

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

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

(3) is an Indian as defined by section 4 of the Indian Health Care Improvement Act; or,

(4) lived for one (1) or more days during the sixty (60) days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no qualified health plan was available.

4. Section 2.6B.1g) in the Individual Enrollment Agreement is amended to add the following:

(4) who was previously ineligible for Advance Payments of the Premium Tax Credit solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion State, who either experiences a change in household income or moves to a different State resulting in the qualified individual becoming newly eligible for Advance Payments of the Premium Tax Credit.

A Subscriber or his or her enrolled Dependents who is newly eligible for cost-sharing reductions and not enrolled in a silver-level QHP may enroll only in a silver-level QHP. A Subscriber or his or her enrolled Dependents who is newly eligible for advanced premium tax credits or newly ineligible for advanced premium tax credits or cost-sharing reductions may enroll in any QHP.

5. Section 2.6B.1h) in the Individual Enrollment Agreement is deleted and replaced with the following:

h) The eligible individual or his or her Dependent becomes eligible as a result of a permanent move and either:

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

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

(3) lived for one (1) or more days during the sixty (60) days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no qualified health plan was available.

The eligible individual or his or her Dependent may access this Special Enrollment Period sixty (60) days before or after the date of the permanent move.

6. Section 2.6B.1.i) in the Individual Enrollment Agreement is deleted and replaced with the following:

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

7. Section 2.6B.1 in the Individual Enrollment Agreement is amended to add the following:

l) The eligible individual or his or her Dependent becomes eligible for coverage as a result of a release from incarceration.

m) The eligible individual or his or her Dependent:

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

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

n) The eligible individual or his or her Dependent:

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

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

o) The eligible individual, or his or her Dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, Service Area, or Premium influenced the eligible individual's decision to purchase a QHP through the Exchange.

p) At the option of the Exchange, the Qualified Individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 CFR §155.315 or is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.

8. Section 2.6C.2. .a)(4) and (5) in the Individual Enrollment Agreement is amended to add the following:

(4) For a child placed for foster care, the date of the placement by the foster care agency. If permitted by the Exchange, the Qualified Individual or enrollee may instead select an Effective Date of the first of the month following the date of placement by the foster care agency or in accordance with Section 2.6C.7. The foster child is not eligible for coverage under the Agreement.

(5) For a child subject to a child support order (MCSO or other court order), the date of the child support order or other court order. If permitted by the Exchange, the Qualified Individual or enrollee may instead select an Effective Date of the first of the month following the date of the child support order or other court order or in accordance with Section 2.6C.7. The foster child is not eligible for coverage under the Agreement.

9. Item 2.6C.2.b) in the Individual Enrollment Agreement is renumbered to be Item 2.6C.2.c).

10. Section 2.6C.5 and 2.6C.6 in the Individual Enrollment Agreement are deleted and replaced with the following:

5. The Effective Date for a Qualified Individual or Dependent who qualifies for a triggering event as described in Section 2.6B.1.a), 2.6B.1.g)(3) or 2.6B.1.g)(4) who enrolls during a Special Enrollment Period shall be the first day of the month following trigger event if the plan selection is made before or on the day of the triggering event. If the plan selection is made after the triggering event, the Effective Date of coverage is as described in Section 2.6C.7. The effective date for a Qualified Individual who gains coverage as described in Section 2.6B.1.h) and 2.6B.1.l who enrolls during a Special Enrollment Period shall be the first day of the month following the date of the permanent move or release from incarceration if the plan selection is made on or before the date of the permanent move or release from incarceration. If the plan selection is made after the date of the permanent move or release from incarceration, the Effective Date of coverage is as described in Section 2.6C.7.

6. The Effective Date for a Qualified Individual or Dependent who enrolls due to a qualifying event stated in (i) Section 2.6B.1.d) (enrollment or non-enrollment was unintentional, inadvertent, or erroneous and is the result of an error by the Exchange or the United States Department of Health and Human Services), (ii) Section 2.6B.1.f) (a Qualified Health Plan substantially violated a material provision of its contract), (iii) Section 2.6B.1.j) (other exceptional circumstances as determined by the Exchange), (iv) Section 2.6B.1.k) (misconduct by a non-Exchange entity as determined by the Exchange), (v) Section 2.6B.1.n) (deemed eligible or applied for Medicaid or CHIP coverage and was subsequently denied), (vi) Section 2.6B.1.o) (demonstrates that a material error occurred), and (vii) Section 2.6B.1.p) (termination of enrollment due to non-timely verification of eligibility by the Exchange) shall be the appropriate date based on the circumstances of the Special Enrollment Period as determined by the Exchange.

11. Section 2.6C in the Individual Enrollment Agreement is amended to add the following:

8. At the option of the Qualified Individual, the Exchange will provide an appropriate coverage effective date that is later than the effective date specified in the provisions of this section if the Qualified Individual's enrollment is delayed until after the Exchange's verification of the Qualified Individual 's eligibility for a Special Enrollment Period, and the assignment of an Effective Date consistent with the provisions in this section would result in the Qualified Individual being required to pay two or more months of retroactive premium to effectuate coverage or avoid termination for non-payment. The late effective date provided by the Exchange will be no later than one (1) month later than the effective date the consumer is entitled to as a result of a special enrollment period.

12. Item 2.6C.8 in the Individual Enrollment Agreement is renumbered to be Item 2.6C.9.

SECTION C - TERMINATION OF ENROLLMENT BY THE SUBSCRIBER

Section 4.1C of the Individual Enrollment Agreement is deleted and replaced with the following:

C. The effective date of a termination of a Member or this Agreement, when initiated by the Subscriber, will be:

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

2. If the Subscriber or Application Filer does not provide reasonable notice, fourteen (14) days after the date the Subscriber or Application Filer requested termination; or at the option of the Exchange, on the date on which the termination is requested by the Subscriber or Application Filer, or on another prospective date selected by the Subscriber or Application Filer; or, if the Exchange does not require an earlier termination date in accordance with this paragraph, at the option CareFirst BlueChoice, on a date on or after the termination is requested by the Subscriber or Application Filer that is less than 14 days after the termination is requested by the Subscriber or Application Filer , if the Subscriber or Application Filer requests an earlier termination date; or at the option of the Exchange, for an individual who is newly determined eligible for Medicaid, CHIP, or the Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange, the day before the Subscriber or Application Filer 's date of eligibility for Medicaid, CHIP, or the Basic Health Program.

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

4. In the case of retroactive termination under Section 4.1A.4.a), the termination date will be no sooner than fourteen (14) days after the date that the Subscriber, Dependents or Application Filer can demonstrate he or she contacted the Exchange to terminate his or her coverage or enrollment through the Exchange, unless CareFirst BlueChoice agrees to an earlier effective date.

5. In case of a retroactive cancellation or termination in accordance with Sections 4.1A.4.b) or c), the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination.

6. In the case of retroactive cancellations or terminations in accordance with Section 4.1A.4, such terminations or cancellations for the preceding coverage year must be initiated within a timeframe established by the Exchange based on a balance of operational needs and consumer protection. This timeframe will not apply to cases adjudicated through the appeals process.

7. The retroactive termination date requested by the Subscriber if specified and applicable under Maryland law.

SECTION D - TERMINATION OF AGREEMENT BY CAREFIRST BLUECHOICE OR THE EXCHANGE

1. Introductory Paragraph of Section 4.2 of the Individual Enrollment Agreement is deleted and replaced with the following:

4.2 Termination of Agreement by CareFirst BlueChoice or the Exchange. CareFirst BlueChoice or the Exchange may terminate the Agreement or the enrollment of a Dependent under the following circumstances by providing notice of termination, including the termination date and the reason for termination, to the Subscriber or Application Filer promptly and without undue delay.

2. Section 4.2D.3 in the Individual Enrollment Agreement is deleted and replaced with the following:

3. The Subscriber no longer resides, lives or works in the Service Area. In such a case, the enrollment of the Subscriber and all Dependents will be terminated with ninety (90) days prior written notice. Coverage is terminated under this provision uniformly without regard to any health status-related factor of covered individuals.

3. Section 4.2D in the Individual Enrollment Agreement is amended to add the following:

6. Non-Renewal Due to Medicare Entitlement or Enrollment. CareFirst BlueChoice reserves the right to terminate this Agreement at renewal if a Member becomes entitled to or enrolled in Medicare and cannot be renewed into the same policy or contract of insurance as set forth in 45 CFR 147.106.

SECTION E – RESCISSION

Section 4.3 in the Individual Enrollment Agreement is amended to add the following:

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

SECTION F - TERMINATION DUE TO DEATH OF THE SUBSCRIBER

Section 4.5, Death of a Subscriber, in the Individual Enrollment Agreement, is deleted and replaced with the following:

4.5 Death of Subscriber. In case of the death of the Subscriber;

A. If the Subscriber has enrolled a Spouse or Domestic Partner as a Dependent, the Spouse or Domestic Partner may remain on the policy and will become the successor Subscriber, or the Spouse or Domestic Partner may terminate the policy as of the date of the Subscriber's death in order to qualify for a special enrollment period.

B. If the Subscriber has enrolled one or more Dependent Children (but not a Spouse or Domestic Partner), the Agreement will terminate on the date of the Subscriber's death. The Dependent Children may enroll into their own child-only policy through a special enrollment period. If the Dependent Child keeps the same plan that they were previously enrolled in prior to the Subscriber's death, CareFirst BlueChoice will apply the same Benefit Year Effective Date to the new policy and will credit the Dependent Child with any Deductibles or cost-sharing that were accrued to the Dependent Child under the former policy for that Benefit Year.

C. If only the Subscriber is enrolled, the Agreement will terminate on the date of the Subscriber's death.

SECTION G – SUBROGATION

Section 5.4, Subrogation, in the Individual Enrollment Agreement is deleted and replaced with the following:

5.4 Subrogation

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

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

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

3. Covered by No Fault Insurance. No Fault Insurance means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose. CareFirst BlueChoice will not subrogate a recovery made under Personal Injury Protection policy benefits.

B. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Agreement, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst BlueChoice provided or will provide benefits. CareFirst BlueChoice may recover the amounts paid in benefits up to the amount received from or on behalf of the third party. CareFirst BlueChoice will not recover from payments made to the Member under the Member's personal injury protection benefits of their motor vehicle insurance policy. CareFirst BlueChoice will not recover medical expenses from a Subscriber unless the Subscriber or Member recovers for medical expenses in a cause of action or settlement.

C. CareFirst BlueChoice's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. CareFirst BlueChoice will reduce the amount owed by the Member to CareFirst BlueChoice pursuant to §11-112(c) of the Courts and Judicial Proceedings Article.

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

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

For purposes of this provision, "made whole" means that the Member fully recovers all their damages.

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

SECTION H – DIABETES TREATMENT

1. Section 1.7, Diabetes Treatment, in the Description of Covered Services, is deleted and replaced with the following:

1.7 Diabetes Treatment.

A. Coverage will be provided for Medically Necessary diabetes treatment and outpatient self-management training and educational services, including medical nutritional counseling at a CareFirst BlueChoice-approved facility. Diabetic equipment and Diabetic Supplies are covered under the Medical Devices and Supplies Section within the Description of Covered Services. Diabetic Supplies are also covered under the Prescription Drug Section within the Description of Covered Services.

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

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

2. Section 11.1.E in the Description of Covered Services is deleted and replaced with the following:

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

1. Diabetes equipment includes glucose monitoring equipment under the durable medical equipment coverage for insulin-using beneficiaries. Coverage will be provided for insulin pumps.

2. Diabetes supplies include coverage for insulin syringes and needles and testing strips for glucose monitoring equipment for insulin-using beneficiaries. Diabetic Supplies are also covered under the Prescription Drug Section

3. Insulin using beneficiary means a Member who uses insulin as part of a treatment plan prescribed by his/her medical care provider.

SECTION I – HABILITATIVE SERVICES

Section 1.10, Habilitative Services, in the Description of Covered Services, is deleted and replaced with the following:

1.10 Habilitative Services.

A. Members until the end of the month in which the Member turns nineteen (19) years old.

1. Coverage for Habilitative services includes health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include services for cleft lip and cleft palate, orthodontics, oral surgery, otologic, audiological, and speech therapy, physical therapy, occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

3. Benefits are not counted toward any visit maximum for Outpatient Rehabilitation Therapy services.

B. For Members age nineteen (19) and over.

1. Benefits are available to Members on the first day of the month after the Member turns age nineteen (19).

2. Coverage for Habilitative services includes health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. These services

may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

3. Benefits are available to the same extent as benefits provided for Outpatient Rehabilitative Services.

C. Prior authorization is required.

SECTION J – SUBSTANCE USE DISORDER

All references to "Substance Abuse" in the Agreement are deleted and replaced with "Substance Use Disorder".

SECTION K – PRESCRIPTION DRUGS

1. Section 12, Prescription Drugs, in the Description of Covered Services, is deleted and replaced with the following:

SECTION 12
PRESCRIPTION DRUGS

12.1 Covered Services. Except as provided in Section 12.4 below, benefits will be provided for Covered Prescription Drugs, including but not limited to:

A. Contraceptive Drugs and Devices.

1. Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. See Section 1.5C, Contraceptive Methods and Counseling, for additional coverage of contraceptive drugs and devices.

   A contraceptive drug or device that is approved by the FDA and obtained under a written prescription will not be subject to a Copayment or Coinsurance.

2. Coverage will be provided to a Member for a contraceptive drug approved by the FDA and available by prescription or Over-the Counter without a prescription written by an authorized prescriber if obtained from a Contracting Pharmacy Provider.

   A contraceptive drug that is approved by the FDA and obtained without a written prescription will not be subject to a Copayment or Coinsurance if the contraceptive drug is purchased from a Contracting Pharmacy Provider.

   To receive a Brand Name Contraceptive Drug at no cost share when there is a Generic Drug available, prior authorization is required. Without prior authorization, the Member will be responsible for the applicable cost share.

3. If the contraceptive drug or device is purchased from a Non-Contracting Pharmacy Provider, amounts in excess of the Prescription Drug Allowed Benefit are a non-Covered Service.

B. Human growth hormones. Prior authorization is required.

C. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preventive Drug List.

Nicotine Replacement Therapy. Nicotine Replacement Therapy means a product, including a product on the Preventive Drug List that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.

D. Injectable medications that are self-administered and the prescribed syringes and needles.

E. Standard covered items such as insulin, glucagon and anaphylaxis kits.

F. Fluoride products.

G. Diabetic Supplies.

H. Infertility drugs or agents, prescribed in connection with, and subject to the limitations of, covered infertility services.

I. Abuse-Deterrent Opioid Analgesic Drug Products.

12.2 Dispensing.

A. Non-Maintenance Drugs are limited to up to a thirty (30)-day supply. For a partial supply of Prescription Drug, the Copayment or Coinsurance will be prorated on a daily basis not to exceed the amount due for a 30-day supply as stated in the Schedule of Benefits.

B. Maintenance Drugs are limited to up to a ninety (90)-day supply. For a partial supply of Prescription Drug, the Copayment or Coinsurance will be prorated on a daily basis not to exceed the amount due for a 90-day supply as stated in the Schedule of Benefits.

C. Contraceptive drugs and devices:

1. Coverage will be provided for a single dispensing of a six (6) month supply of prescription contraceptives.

2. Provision C.1 does not apply if:

a) The six (6) month supply would extend beyond the end of the Benefit Period. In which case the Member would be able to receive up to a ninety (90)-day supply; or,

b) The coverage is for the first two (2) month supply dispensed to the Member under:

i) The initial prescription for contraceptives; or,

ii) Any subsequent prescription for a contraceptive that is different from the last contraceptive dispensed to the Member.

D. When a partial supply of Prescription Drug is dispensed by Contracting Pharmacy, a prorated daily copayment or coinsurance for the partial supply of the Prescription Drug shall be applied if:

1. The prescriber or the Pharmacist determines dispensing a partial supply of a Prescription Drug to be in the best interest of the member;

2. The Prescription Drug is anticipated to be required for more than 3 months;

3. The member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the member's Prescription Drugs;

4. The Prescription Drug is not a Schedule II controlled dangerous substance; and

5. The supply and dispensing of the Prescription Drug meets all prior authorization and utilization management requirements specific to the Prescription Drug at the time of the synchronized dispensing.

This provision applies only to a partial supply of Prescription Drugs dispensed by a Contracting Pharmacy.

12.3 Mail Order Program. Except as provided in Section 12.4 below, all Members have the option of ordering Covered Prescription Drugs via mail order. Members ordering Covered Prescription Drugs through the mail order program will be entitled to a thirty (30) day supply for non-Maintenance Drugs and a ninety (90) day supply for Maintenance Drugs. Except as provided in Section 12.2C.2), a six (6) month supply of prescription contraceptive drugs is available via the mail order program.

12.4 Benefits for Specialty Drugs. Benefits will be provided for Covered Specialty Drugs only when obtained from a Pharmacy that is part of the Exclusive Specialty Pharmacy Network.

12.5 Step Therapy or Fail-First Protocol. Prescription Drugs subject to Step Therapy or Fail-First Protocols are listed in the Prescription Guidelines.

A. CareFirst BlueChoice will not impose a Step Therapy or Fail-First Protocol on a Member if:

1. The Step Therapy Drug has not been approved by the FDA for the medical condition being treated; or,

2. The Member's prescribing provider provides Supporting Medical Information to CareFirst BlueChoice that a covered Prescription Drug:

a) Was ordered for the Member by a prescriber for the Member within the past one hundred eighty (180) days; and,

b) Based on the professional judgment of the Member's prescribing provider, was effective in treating the Member's disease or medical condition.

B. CareFirst BlueChoice will not impose a Step Therapy or Fail-First Protocol on a Member for a Prescription Drug approved by the FDA if:

1. The Prescription Drug is used to treat the Member's Stage 4 advanced metastatic cancer; and,

2. Use of the Prescription Drug is:

a) Consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of Stage 4 advanced metastatic cancer; and,

b) Supported by peer-reviewed medical Literature.

2. Section 15.8, Prescription Drug Coverage, in the Description of Covered Services, is deleted and replaced with the following:

15.8 Prescription Drug Coverage.

A. Accessing the Prescription Drug Benefit Card Program.

1. Members may use his/her identification card to purchase Covered Prescription Drugs from Contracting Pharmacy Providers. If the Prescription Drug coverage includes a Deductible, the Member must pay the entire cost of the Covered Prescription Drug(s) until the Deductible is satisfied. Once the Deductible, if applicable, has been satisfied, the Member pays the appropriate Copayment or Coinsurance as stated in the Schedule of Benefits.

2. For Covered Prescription Drugs or diabetic supplies purchased from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. In cases of Emergency Services or Urgent Care received outside of the Service Area, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance. In all other cases, Members will be entitled to reimbursement from CareFirst BlueChoice or its designee for the amount up to the Prescription Drug Allowed Benefit, minus any applicable Deductible, or Copayment or Coinsurance. Charges in excess of the Prescription Drug Allowed Benefit are a non-Covered Service.

3. Except for Specialty Drugs, Members have the option of ordering Covered Prescription Drugs via mail order. The mail order program provides Members with a Pharmacy that has an agreement with CareFirst BlueChoice or its designee, to provide mail service for Covered Prescription Drugs in accordance with the terms of this provision. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance.

B. Additional Terms and Conditions.

1. Members or health care providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Covered Prescription Drug in the Prescription Guidelines. A copy of the Prescription Guidelines is available to the Member or provider upon request.

Except for a contraceptive drug or device for which the FDA has issued a black box warning, prior authorization will not be required for a contraceptive drug or device that is:

a) an intrauterine device or an implantable rod;

b) approved by the FDA; and,

c) obtained under a prescription written by an authorized prescriber.

To receive a Brand Name Contraceptive Drug at no cost share when there is a Generic Drug available, prior authorization is required. Without prior authorization, the Member will be responsible for the applicable cost share.

2. Providers may substitute a Generic Drug for a Brand Name Drug. If there is no Generic Drug for the Brand Name Drug the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits for Preferred Brand Name Drugs or Non-Preferred Brand Name Drugs.

3. If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment or Coinsurance when Medically Necessary, as determined by CareFirst BlueChoice.

4. When a Generic version of a Prescription Drug becomes available, the Brand Name Drug may be removed from the Formulary or moved to the Non-Preferred level.

5. Except for a refill of prescription eye drops, Members must use 80% of a dispensed non-Maintenance Drug or Maintenance Drug in the manner prescribed before a refill of that prescription can be obtained.

   Coverage for a refill of prescription eye drops shall be provided in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid Services; and, if:

   a) the prescribing health care practitioner indicates on the original prescription that additional quantities of the prescription eye drops are needed;

   b) the refill requested by the Member does not exceed the number of additional quantities indicated on the original prescription by the prescribing health care practitioner; and,

   c) the prescription eye drops prescribed by the health care practitioner are a covered benefit under the Agreement.

6. The Member is responsible for obtaining prior authorization for Covered Prescription Drugs in the Prescription Guidelines when obtained from a non-Contracting Pharmacy Provider by calling the customer service telephone number listed on the identification card.

   Except for a contraceptive drug or device for which the FDA has issued a black box warning, prior authorization will not be required for a contraceptive drug or device that is:

   a) an intrauterine device or an implantable rod;

   b) approved by the FDA; and,

   c) obtained under a prescription written by an authorized prescriber.

   To receive a Brand Name Contraceptive Drug at no cost share when there is a Generic Drug available, prior authorization is required. Without prior authorization, the Member will be responsible for the applicable cost share.

C. How to Obtain Prescription Drugs Not Included in the CareFirst BlueChoice Formulary. The Member may request an exception for coverage of a Prescription Drug not contained on the CareFirst BlueChoice Formulary.

1. The Member, the Member's authorized representative or the Member's provider may request an exception based upon clinical appropriateness by contacting the CareFirst BlueChoice at the telephone number located on the back of the Member's identification card.

2. An exception form should be submitted by the prescribing provider and returned to CareFirst BlueChoice. The prescribing provider may submit a letter of Medical Necessity for dispensing of the non-Covered Prescription Drug.

   CareFirst BlueChoice will provide coverage for the non-Covered Prescription Drug if, in the judgement of the prescribing provider:

   a) there is no equivalent Prescription Drug in the Formulary;

   b) an equivalent Prescription Drug in the Formulary:

      (1) has been ineffective in treating the Member's disease or condition; or,

      (2) has caused or is likely to cause an adverse reaction or other harm to the Member; or,

   c) with respect to a contraceptive drug or device, the Prescription Drug that is not on the Formulary is Medically Necessary for the Member to adhere to the appropriate use of the Prescription Drug.

   For purposes of this provision, equivalent means therapeutically equivalent.

   CareFirst BlueChoice will also provide coverage for the non-Covered Prescription Drug when, in CareFirst BlueChoice's determination, the non-Covered Prescription Drug is clinically appropriate for the Member.

3. Upon review by the CareFirst BlueChoice, the prescribing provider and the Member or the Member's representative will be notified.

   a) If the request is approved then the Prescription Drug will be dispensed and the Member will be responsible for the Non-Preferred Brand Name Drug Copayment. If the Prescription Drug exception request is for a non-Formulary Specialty Drug and the exception is granted, then the Member will be responsible for the Non-Preferred Specialty Drug Copayment.

   b) If the exception request is denied, the denial shall be considered an Adverse Decision and may be appealed in accordance with the process outlined in the Benefit Determination and Appeals Amendment.

      In addition, if the exception request is denied, the Member, the Member's representative or the prescribing provider may submit an external exception request to CareFirst BlueChoice requiring that the original exception request and subsequent denial be reviewed by an independent review organization.

4. Timeframe for review and notification of outcome of exception request:

   a) Urgent requests based on exigent circumstances from the Member's prescribing provider will be completed within twenty-four (24) hours.

      For purposes of this provision, exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-Formulary Prescription Drug.

   b) Non-urgent requests will be completed within seventy-two (72) hours.

c) A request for an external review of the exception request will be completed no later than twenty-four (24) hours after receipt of the request if the exception request was urgent and seventy-two (72) hours following receipt of the request if the exception request was non-urgent.

3. Section 16, Exclusions and Limitations, is amended to add the following:

16.55 Except as otherwise provided, Prescription Drugs not contained on the CareFirst BlueChoice Formulary.

SECTION L – BENEFIT DETERMINATION AND APPEAL AND GRIEVANCE PROCEDURES

1. The definition of "Compelling Reason" in Section A of the Benefit Determination and Appeal and Grievance Procedures is deleted and replaced with the following:

Compelling Reason means a showing that the potential delay in receipt of a health care service until after the Member, the Member's Representative or Health Care provider acting on behalf of the Member exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, the Member remaining seriously mentally ill or using intoxicating substances with symptoms that cause the member to be in danger to self or others, or the Member continuing to experience severe withdrawal symptoms.

2. The definition of "Emergency Case" in Section A of the Benefit Determination and Appeal and Grievance Procedures is deleted and replaced with the following:

Emergency Case means medical services are necessary to treat a condition or illness that, without immediate medical attention, would either (i) seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, (ii) cause the Member to be in danger to self or others; or (iii) cause the Member to continue using intoxicating substances in an imminently dangerous manner.

3. Section K, item 10 of the Benefit Determination and Appeal and Grievance Procedures is amended to replace the following address for the Health Education and Advocacy Unit. The address is deleted and replaced with the following:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Maryland Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or 1-877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us
http://www.marylandattorneygeneral.gov/Pages/CPD/heau

4. Section L of the Benefit Determination and Appeal and Grievance Procedures is amended to replace the following address for the Maryland Insurance Administration. The address is deleted and replaced with the following:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation – Life and Health
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000 or 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2270

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

CareFirst BlueChoice, Inc.

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

2018 VISION PLUS AMENDMENT

This amendment is effective. If no date is shown, this amendment is effective on the effective date or renewal date of the Individual Enrollment Agreement to which this amendment is attached.

The Agreement is amended as follows:

ADULT VISION SERVICES

Section 4.0, Adult Vision Services in the Description of Covered Services is deleted and replaced with the following:

4.1 Covered Vision Services. Coverage will be provided for Members age 19 and over for one (1) routine eye examination, including dilation, if professionally indicated, each Benefit Period. A vision examination may include, but is not limited to:

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

Benefits will also be provided for frames, lenses, and contact lenses.

4.2 Limitations. Benefits for treatment of medical conditions of the eye are covered under Section 1.

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

CareFirst BlueChoice, Inc.

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

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TOTAL CARE AND COST IMPROVEMENT, HEALTH PROMOTION, WELLNESS AND DISEASE MANAGEMENT PROGRAM AMENDMENT

This amendment is effective. If no date is shown, this amendment is effective on the effective date or renewal date of the Agreement to which this amendment is attached.

TABLE OF CONTENTS

Section 14, Complex Chronic or High Risk Acute Disease Management in the Description of Covered Services is deleted and replaced with the following:

SECTION 14
TOTAL CARE AND COST IMPROVEMENT, HEALTH PROMOTION, WELLNESS AND DISEASE MANAGEMENT PROGRAM

14.1 Definitions.

Biometric Screening means an onsite event during which Member screenings are provided for various measurements, such as: height, weight, BMI, waist circumference, blood pressure, LDL, HDL, total cholesterol, the total cholesterol to HDL ratio, triglycerides, and glucose.

Behavioral Health Care Coordination Program (BHCC Program) means the assessment and coordination of behavioral health care services to a Member.

Complex Care Coordination Program (CCC Program) means the assessment and coordination of services provided to a Member with multiple chronic and severe health conditions or advanced or critical illnesses.

Disease Management Program means a coordinated, confidential program designed to manage a Member's chronic disease so that action can be taken to improve outcomes in the future.

Disease Management Coaching Session means an interactive coaching session provided to the Member with the Member's consent that furthers the Member's Disease Management Program.

Designated Provider means a provider contracted with CareFirst to provide services under CareFirst's Total Care and Cost Improvement Program, which includes the following components: PCMH Program, BHCC Program, CCC Program, Comprehensive Medication Review, Enhanced Monitoring Program, Expert Consultation Program, Home-Based Services Program, Pharmacy Coordination Program, Substance Use Disorder Program, or other community-based programs outlined in this amendment (collectively, the "TCCI Programs") and who has agreed to participate in care coordination activities in cooperation with CareFirst for Members with complex chronic disease, high risk acute conditions or lifestyle behavior change.

Health Promotion and Wellness Program means a coordinated program, including Lifestyle Management Coaching Sessions, designed to prevent disease, identify a Member's risk factors for disease or detect early stages of a Member's disease so that action can be taken to prevent poor outcomes in the future.

Lifestyle Management Coaching Session means an interactive wellness coaching session provided to the Member with the Member's consent that furthers the Member's Health Promotion and Lifestyle Management Program.

Qualified Member means a Member who:

A. Is participating in and complies with all elements of one or more of the TCCI Programs described in this amendment including use of a Designated Provider;

B. Continues to meet the criteria for participation in the TCCI Program(s) and participates fully with any applicable plan of care or other TCCI Program requirements, including compliance with direction from a Designated Provider when in an active plan of care; and

C. CareFirst and the Member's Designated Provider determine is cooperating with, and satisfying the requirements of, the TCCI Program(s).

CareFirst retains final authority to determine whether a Member is a Qualified Member.

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

Substance Use Disorder Program (SUD Program) means the CareFirst program for Members with a diagnosed Substance Use Disorder. The program includes a maximum of twelve (12) consecutive months of ambulatory/outpatient detoxification, individual therapy, group therapy, and medication assisted therapy.

Weight Loss Services means CareFirst approved services available to clinically overweight or obese (BMI $\geq$ 25) Members for the purpose of achieving measurable weight loss and sustainable weight maintenance, as part of the Health Promotion, Wellness, and Disease Management Program.

14.2 Benefits and Cost Sharing Waiver.

A. To participate in any TCCI Program:

1. CareFirst will consult with a provider to determine whether the Member meets the parameters for and would benefit from participation in one or more of the TCCI Programs; and

2. The Member must consent to participate in and comply with all elements of the TCCI Program(s) in which he/she qualifies including use of a Designated Provider.

B. Members in an active plan of care participating in a BHCC Program, CCC Program, or SUD Program are eligible for the following benefits:

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

2. Education of Member/family regarding illness, provider 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 Designated Provider to deliver and coordinate the Member's care;

5. Assistance in arranging consultation(s) with Specialists or other applicable and medically necessary in-network providers;

6. Identification of and connection to community resources, and other organizations/support services to supplement the Member's plan of care;

7. Implementation of a plan of care under the direction of the Member's provider;

8. Coordination of care, either telephonically or otherwise, between a Designated Provider and a Member and his/her provider; and

9. Other Medically Necessary services provided to a Member while in an active plan of care.

C. Members may simultaneously participate in the CCC Program and either the SUD Program or the BHCC Program, but no Member may simultaneously participate in all three Programs (the BHCC, CCC and SUD Programs).

D. Members are eligible for medically-necessary benefits under the following TCCI Program elements in addition to any benefits in Section 14.2.B, so long as the Member meets the requirements of the applicable TCCI Program element:

1. Comprehensive Medication Review (CMR). Benefits will be provided for a pharmacist's review of medications and consultation with the Qualified Member to improve the effectiveness of pharmaceutical therapy.

2. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Member with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Member's chronic condition or disease.

3. Expert Consultation Program (ECP). Benefits will be provided for a review by a team of Specialists of a Qualified Member's medical records where the Qualified Member has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

4. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in a home-based care management plan. The Member does not need to be confined to the home to participate in HBS.

E. All TCCI Program benefits are subject to applicable contract limits.

F. Qualified Member Cost Sharing Responsibilities.

1. Except as provided in paragraphs 3, 4, and 5, of this Section F, for Qualified Members in an active plan of care in the BHCC Program, CCC Program, or SUD Program, CareFirst shall waive all cost-sharing responsibilities for all medically necessary, in-network covered services.

2. Except as provided in paragraphs 3, 4, and 5, of this Section F, for Qualified Members not in an active plan of care, but in a TCCI Program element, CareFirst shall waive all cost-sharing responsibilities for services in such TCCI Program when provided by a Designated Provider.

3. CareFirst will not waive cost-sharing responsibilities for any (i) prescription or other drug benefits; (ii) institutional claims or facility charges; (iii) services provided on an inpatient basis; (iv) services provided in an emergency department or ambulatory surgical center; (v) ambulance benefits; or (vi) durable medical equipment benefits. Subsection (ii) of this paragraph does not apply to services provided under the HBS Program or to Qualified Members in an intensive outpatient program as part of the SUD Program. Subsection (vi) of paragraph does not apply to services provided under the EMP Program.

4. CareFirst will not waive cost-sharing responsibilities for more than (i) twelve (12) consecutive months for a Member in the SUD Program and (ii) six (6) consecutive months for a Member in any other TCCI Program including the BHCC Program and CCC Program. The duration of any waiver of cost-sharing responsibility will run concurrent with the benefit plan and terminate in accordance with Section 14.2G.

5. If the Qualified Member's Agreement is compatible with a federally-qualified Health Savings Account:

   a) If the Qualified Member has funded his/her HSA account during the Benefit Period, then the Qualified Member will be responsible for any associated costs for services under this Section until the annual Deductible has been met, unless the Covered Services appear on the list of preventive services maintained by the Internal Revenue Service.

   b) If the Qualified Member has not funded his/her HSA account during the Benefit Period, then if the Qualified Member agrees not to fund his/her HSA account and provides a signed agreement not to fund his/her HSA account, then the Qualified Member will be eligible for the waiver described in Section 14.2.F.1.

G. Termination.

1. The Qualified Member's participation in the CCC Program, BHCC Program, or SUD Program, and/or any TCCI Program element and receipt of benefits and cost-sharing waivers under this Section will be terminated under the following circumstances:

   a) The Qualified Member completes the stated goals of the TCCI Program(s) set forth in the Qualified Member's plan of care or other TCCI Program requirements as confirmed by the Qualified Member's Designated Provider.

   b) The Designated Provider determines that the Qualified Member failed to comply with the TCCI Program(s) and/or any related plan of care or treatment under this Section. The Qualified Member will be given thirty (30) days prior written notice of termination under this subsection.

   c) The Qualified Member's coverage under this Agreement is terminated.

2. If termination is the result of the Qualified Member's failure to comply with the TCCI Program(s) under Section 14.2G.1.(b), the Qualified Member will be provided the opportunity to comply with the TCCI Program(s) during the thirty (30) day notice period. If after consultation between the Qualified Member's provider and the Designated Provider a determination is made that the Qualified Member is not and will not be compliant with the applicable TCCI Program(s),

the Qualified Member will receive a final written notice of termination of benefits under this Section.

3. Upon termination of the Qualified Member's participation in the TCCI Program(s), all cost-sharing waivers and benefits shall be null and void on and after the effective date of the termination of the waiver and the Qualified Member will be responsible for any and all cost-sharing responsibilities as stated in the Schedule of Benefits on and after the date of termination of the waiver.

14.3 Health Promotion and Wellness.

A. Health Assessments are available for all adult Members.

B. Benefits are available for Biometric Screening of Members, as defined above.

C. Lifestyle Management Coaching Session services are available as follows:

1. With the Member's consent, an initial discussion with a lifestyle coach to establish defined goal(s) for wellness coaching, and to determine the frequency of future coaching sessions in order to best meet the goal(s) established.

2. After the initial discussion, Coaching Sessions to track, support, and advance the Member's wellness/lifestyle goal(s).

D. Other Wellness Program benefits are available, and shall include tobacco-cessation, well-being challenges, and financial well-being improvement programs.

E. Weight Loss Services are available to clinically overweight or obese Members, as follows:

1. A clinically overweight Member is a Member whose Body Mass Index (BMI) score is equal to or greater than twenty-five (25). A clinically obese Member is a Member whose Body Mass Index (BMI) score is equal to or greater than thirty (30).

2. A dedicated, CareFirst approved coach is assigned to the Member to assist the Member in the development of healthy eating habits, physical activity habits, and to address the emotional, social, and environmental aspects shown to be important for sustained weight loss.

3. The Members receive one-on-one telephonic interventions with the coach and online educational resources, robust food, exercise trackers, recipes, peer-to-peer communication, and group community features for complete social support and accountability.

14.4 Disease Management.

A. Disease Management services, which may include a Disease Management Program to help the Member understand his/her disease and health status and physician treatment plans, individual and family education regarding the disease, treatment compliance and self-care techniques, and help to organize care for the disease, including arranging for needed services and supplies.

B. Disease Management Coaching Session services are available as follows:

1. With the Member's consent, an initial discussion with a coach to establish defined goal(s) for disease management coaching, and to determine the frequency of future coaching sessions in order to best meet the established goal(s) and manage the disease.

2. After the initial discussion, Disease Management Coaching Sessions to track, support, and advance the Member's disease management goal(s).

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

CareFirst BlueChoice, Inc.

Signature

_____

Name
Title

PATIENT PROTECTION DISCLOSURE NOTICE

Primary Care Provider Designation

CareFirst BlueChoice generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, CareFirst BlueChoice designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the CareFirst BlueChoice at the customer service telephone number listed on your identification card.

For children, you may designate a CareFirst BlueChoice pediatrician as the primary care provider.

Obstetrics and Gynecological Care

You do not need prior authorization from CareFirst BlueChoice or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of CareFirst BlueChoice health care professionals who specialize in obstetrics or gynecology, contact CareFirst BlueChoice at customer service telephone number listed on your identification card.

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
202-479-8000

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COMPENSATION AND PREMIUM DISCLOSURE STATEMENT

Our compensation to providers who offer health care services and behavioral health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your physician, please call our Member Services Department at the number listed on your identification card, or write to:

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
Attention: Member Services

A. METHODS OF PAYING PHYSICIANS

This table shows definitions of how insurance carriers may pay physicians (or other providers) for your health care services with a simple example of how each payment mechanism works.	
Terms	The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.
Salary	A physician (or other provider) is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services. Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing pre-natal care to Mrs. Smith, who is a member of the HMO, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have an effect upon Dr. Jones' salary.
Capitation	A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires. Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.

This table shows definitions of how insurance carriers may pay physicians (or other providers) for your health care services with a simple example of how each payment mechanism works.	
Fee-for- Service	A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder. Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.
Discounted Fee-for-Service	Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician (or other provider), who usually gets an increased volume of patients. Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs. Dr. Jones will be paid a discounted rate by the insurer or HMO.
Bonus	A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services. An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.
Case Rate	The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care. This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.

B. PERCENTAGE OF PROVIDER PAYMENT METHODS

CareFirst BlueChoice, Inc. is a network model HMO and contracts directly with the primary care and specialty care providers. According to this type of arrangement, CareFirst BlueChoice, Inc. reimburses providers primarily on a discounted fee-for-service payment method. The provider payment method percentages for CareFirst BlueChoice, Inc. are approximately 99% discounted fee-for-service and less than 1% capitated.

C. DISTRIBUTION OF PREMIUM DOLLARS

The bar graph below illustrates the proportion of every $100 in premium used by CareFirst BlueChoice, Inc. to pay providers for medical care expenses, and the proportion used to pay for plan administration.

These numbers represent an average for all HMO accounts based on our annual statement. The ratio of direct medical care expenses to plan administration will vary by account.

The composite distribution presented in this disclosure is presented pursuant to the requirements of Maryland law, and may differ from calculations of federal medical loss ratio for a carrier in a particular market under the requirements of the Patient Protection and Affordable Care Act, based on accounting differences in the formulae used.