CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
10455 Mill Run Circle
Owings Mills, MD 21117-5559

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

An independent licensee of the Blue Cross and Blue Shield Association

STUDENT HEALTH PLAN
INDIVIDUAL ENROLLMENT AGREEMENT

This Agreement, including any duly authorized attachments, notices, amendments, and riders, is a part of the Academic Institution Contract issued to the Academic Institution (Institution of Higher Education) through which Subscribers are enrolled for covered health benefits. The Academic Institution Contract, in its entirety, of which this Agreement is a part, is the complete contract between CareFirst and the Academic Institution.

The Academic Institution accepts and agrees to the Academic Institution Contract by making payment of the initial Premium to CareFirst. CareFirst agrees to the Academic Institution Contract when it is issued to the Academic Institution.

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

Subscriber Name: _____

Subscriber ID Number: _____

Agreement Effective Date: August 1, 2016

Product: BluePreferred PPO Student Health Plan Gold $250

Term: This Agreement will have an initial term from the Agreement Effective Date stated above until the last day of the Academic Institution Contract year.

CareFirst of Maryland, Inc.

Chester E. Burrell
President and Chief Executive Officer

SECTION 1
DEFINITIONS

The underlined terms when capitalized are defined as follows:

Academic Institution means the organization to which CareFirst has issued an Academic Institution Contract pursuant to which Eligible Students and their Dependents, to the extent such dependents are covered under this Agreement, are enrolled for covered health benefits. as set forth herein.

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

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.

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 policy, which includes all attachments, amendments and riders, if any, between the Academic Institution and CareFirst (also referred to as the Academic Institution Contract).

Allowed Benefit means:

For a Preferred Provider: The Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency, or the amount CareFirst allows for the service in effect on the date that the service is rendered, except for facilities that are paid in accordance with Diagnosis Related Groups ("DRG's"). The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.

For a Non-Preferred Provider that is a health care practitioner:

A. For a Covered Service rendered by an On-Call Physician or a Hospital-Based Physician who accepts an Assignment of Benefits, the Allowed Benefit is:

1. For a Hospital-Based Physician, no less than the greater of:

a) 140% of the average rate CareFirst paid for the 12-month period that ends on January 1 of the previous Calendar Year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to similarly licensed providers, who are Hospital-Based Physicians under written contract with CareFirst; or

b) The final allowed amount of CareFirst for the same Covered Service for the 12-month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the Hospital-Based Physician billing under the same federal tax identification number the Hospital-Based Physician used in Calendar Year 2009.

2. For an On-Call Physician, no less than the greater of:

a) 140% of the average rate CareFirst paid for the 12-month period that ends on January 1 of the previous Calendar Year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to similarly licensed providers under written

contract with CareFirst; or

b) The average rate CareFirst paid for the 12-months period that ended on January 1, 2010, in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to a similarly licensed provider not under written contract with CareFirst inflated by the change in the Medicare Economic Index from 2010 to the current year.

The benefit is payable to the On-Call Physician or Hospital-Based Physician who accepts an Assignment of Benefits, except as provided in Section 6.3C, and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.

B. For a Covered Service rendered by an Ambulance Service Provider: The Allowed Benefit for a Covered Service provided by an Ambulance Service Provider that is a Non-Preferred Provider may not be less than the Allowed Benefit paid to a Preferred Ambulance Service Provider for the same Covered Service in the same geographic region, as defined by the Centers for Medicare and Medicaid Services. The benefit is payable to the Ambulance Service Provider in the State of Maryland who accepts an Assignment of Benefits, except as provided in Section 6.3C, and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.

C. For a Covered Service rendered by a United States Department of Defense or United States Department of Veterans Affairs health care provider: the Allowed Benefit for a Covered Service rendered by a Non-Preferred Provider that is a United Stated Department of Defense or United States Department of Veterans Affairs health care provider will be no less than the health care provider's actual charge. Benefit payments will be made directly to a United States Department of Defense and the United States Department of Veteran Affairs health care provider.

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

E. For a Covered Service rendered within the Service Area by any other Non-Preferred Provider that is a health care facility, the Allowed Benefit for a Covered Service may be a rate set by a regulatory agency and is no less than the allowed amount paid to a similarly licensed provider who is a Preferred Provider that is a health care facility for the same Covered Service in the same geographic region. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with a health care provider. In that instance, the CareFirst payment will be based on the negotiated fee and the health care provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits. The benefit is payable to the Member or to the Non-Preferred Provider at the discretion of CareFirst. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Preferred Provider. In any event, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and, unless the fee is negotiated, for any Balance Bill.

F. For a Covered Service rendered within the Service Area by any other Non-Preferred Provider, including a provider of ambulance services that is not an Ambulance Services Provider: The Allowed Benefit for a Covered Service is no less than the amount paid to a similarly licensed provider who is a Preferred Provider for the same Covered Service in the same geographic region. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with a health care provider. In that instance, the CareFirst payment will be based on the negotiated fee and the health care provider agrees to accept

the amount as payment in full except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits. For a Non-Preferred Provider who is a physician, the benefit is payable to the physician if the Member has given an Assignment of Benefits, except as provided in Section 6.3C. For any other Non-Preferred Provider who is a health care practitioner, the benefit is payable to the Member or to the Non-Preferred Provider at the discretion of CareFirst. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Preferred Provider. In any event, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and, unless the fee is negotiated, for any Balance Bill.

G. For Covered Services rendered outside the CareFirst Service Area, see the Inter-Plan Arrangements Disclosure Amendment attached to this Individual Enrollment Agreement for information.

Pediatric Dental Allowed Benefit means:

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

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

C. For Non-Participating Dentists, the Pediatric Dental Allowed Benefit for a Covered Dental Service will be determined in the same manner as the Allowed Benefit payable to a Participating Dentist. For a Non-Participating Dentist who is a physician, the benefit is payable to the physician if the Member has given an Assignment of Benefits, except as provided in Section 6.3C. For any other Non-Participating Dentist, the benefit is payable to the Member or to the Non-Participating Dentist at the discretion of CareFirst. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Participating Dentist. In any event, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and for any Balance Bill.

Prescription Drug Allowed Benefit means the lesser of:

A. The Pharmacy's actual charge; or

B. The benefit amount, according to the CareFirst fee schedule, for covered Prescription Drugs that applies on the date 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. The Member is responsible for any applicable Deductible, Copayment or Coinsurance and the Contracting Pharmacy Provider may bill the Member directly for such amounts.

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 or its designee for reimbursement. The Prescription Drug Allowed Benefit for a covered Prescription Drug will be determined in the same manner as the Prescription Drug Allowed Benefit to a Contracting Pharmacy Provider, less any applicable Deductible, Copayment or Coinsurance. The Member will be entitled to reimbursement from CareFirst or its designee for the amount up to the Prescription Drug Allowed Benefit, minus any applicable Deductible, Copayment or Coinsurance and the Member is responsible for any balances above the Prescription Drug Allowed Benefit.

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 benefit payment is made directly to a Contracting Vision Provider. When a Member receives a Covered Vision Service from a Contracting Vision Provider, the benefit payment is accepted as payment in full, except for any applicable Copayment or Coinsurance stated in the Schedule of Benefits. The Contracting Vision Provider may collect any applicable Copayment or Coinsurance.

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 benefit amounts stated in the Schedule of Benefits, as compared to the benefit amounts provided on the Vision Care Designee's Contracting Vision Provider rate schedule, will be no less than the benefit amounts required to comply with § 14-205 of the Insurance Code.

For a Non-Contracting Vision Provider who is a physician, the benefit is payable to the physician if the Member has given an Assignment of Benefits, except as provided in Section 6.3C. For any other Non-Contracting Vision Provider, the benefit is payable to the Member or to the Non-Contracting Vision Provider at the discretion of the Vision Care Designee. It is the Member's responsibility to apply any Vision Care Designee payments received to the claim from the Non-Contracting Vision Provider. In any event, the Member is responsible for any Balance Bill.

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 Contract Year during which an eligible individual may enroll or change coverage under this Agreement.

Assignment of Benefits means the transfer of health care coverage reimbursement benefits or other rights under the Agreement by, or on behalf of, the Member to a physician, a Hospital-Based Physician, an On-Call Physician or an Ambulance Service Provider pursuant to Annotated Code of Maryland, Insurance Article §14-205.2, §14-205.3 or §15-138.

Balance Bill means:

A. For Covered Services, the difference between a Non-Preferred Provider's actual charge for a Covered Service and the Allowed Benefit.

B. For Covered Dental Services, the difference between a Non-Participating Dentist's actual charge for a Covered Dental Service and the Pediatric Dental Allowed Benefit.

C. For a Covered Vision Service, the difference between a Non-Contracting Vision Provider's actual charge for a Covered Vision Service and the Vision Allowed Benefit.

Benefit Period means the Contract Year or Calendar Year, as determined by the Academic Institution, 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.

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

Caregiver means a person 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 charges for providing services. At CareFirst's discretion, a Caregiver may be an employee of a hospice care hospital/agency.

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

Contract Year means 365 days from the effective date of the Agreement each year.

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

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. A drug trial that is exempt from having an FDA-approved investigational new drug application.

10. 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.

Co-Surgery means when two or more surgeons of the same or different specialties are required to perform the same surgical procedure.

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.

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

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

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.

Eligible Student means an individual eligible under the guidelines defined by the Academic Institution sponsoring this Agreement who is an admitted or continuing candidate in a recognized degree or certificate program sponsored by the Academic Institution. For purposes of this definition, "Candidacy in a recognized degree or certificate program" is defined as:

A. Candidacy during academic semester

A student is an admitted or continuing candidate in a recognized degree or certificate program if the student is actively pursuing the course of study required by the degree or certificate program. The student must satisfy the requirements of his course of study which may involve maintaining minimum credit hours, research units or involvement in approved intern or work/study programs. Academic semester may include summer. Additionally, eligibility may be defined as continuing education courses, affiliated research assistantships, or post-doctoral research after graduation from a recognized degree program (e.g., a student fellowship).

B. Candidacy between academic semesters

A student who maintains candidacy in a recognized degree or certificate program during an academic semester or session keeps such candidacy until the close of the next semester's or session's registration period.

A student's eligibility may continue in this manner until the student's candidacy is withdrawn by the student or terminated by the institution.

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 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)).

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

Exchange means the Maryland Health Benefits Exchange.

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

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.

Hospital-Based Physician means a Non-Preferred Provider who is:

A. A physician licensed in the State of Maryland who is under contract to provide health care services to patients at a hospital; or

B. A group physician practice that includes physicians licensed in the State of Maryland that is under contract to provide health care services to patients at a hospital.

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 includes enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. Infusion Services includes all medications administered intravenously and/or parenterally.

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. 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 an individual who meets all applicable eligibility requirements, who is enrolled either as a Subscriber or Dependent, and for whom Premiums have been collected by the Academic Institution and remitted to CareFirst.

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

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

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

On-Call Physician means a Non-Preferred Provider who is a physician and who:

A. Has privileges at a hospital;

B. Is required to respond within an agreed upon time period to provide health care services for unassigned patients at the request of a hospital or hospital emergency department; and

C. Is not a Hospital-Based Physician.

Opioid Analgesic Drug Product means a drug product that contains an opiod 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, 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 CareFirst, or CareFirst's designee, 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 by the attending health care provider on CareFirst forms which shows the Member's diagnoses and needed treatment.

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

Preferred Dentist means one of a network of Participating Dentists who, at the time of rendering a Covered Dental Service to a Member, has a written agreement with CareFirst, or CareFirst's designee, 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 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 may change this list periodically without notice to Members. A copy of the Preferred Drug List is available to the Member upon request.

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

Premium means the dollar amount the Academic Institution on behalf of the Subscriber remits to CareFirst for health care benefits provided under this Agreement.

Premium Due Date is the date determined by CareFirst.

Prescription Drug means

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

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

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

D. Any Diabetic Supply.

E. Prescription Drugs do not include:

1. Compounded bulk powders that contain ingredients that:

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

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

c) Do not require a prescription to be dispensed.

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

a) There is no commercially available 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.

Prescription Guidelines means the limited list of Prescription Drugs issued by CareFirst for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from CareFirst, the quantity limits the CareFirst 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.

Primary Care Physician (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 that meets the health plan 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.

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

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.

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 an eligible individual, who experiences one or more qualifying events, may enroll in, or change enrollment under this Agreement outside of any Annual Open Enrollment Period.

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

Specialty Drug 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 the dispensing amount for non-Maintenance Drugs stated in the Schedule of Benefits.;

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 an 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 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 Eligible Student 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 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 and the provider prescribing the Step Therapy Drug.

Surgical Assistant means a provider who assists a physician during an operative procedure. The assistant may be a medical doctor, podiatrist, oral surgeon, physician assistant, nurse midwife, nurse practitioner, or registered nurse first assistant.

Team Surgery means when two or more surgeons of the same or different specialties are required to perform separate portions of the same surgical procedure at the same time.

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

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

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage.

A. The individual must be eligible for coverage either as a Subscriber or if applicable, as a Dependent;

B. The Subscriber and any Dependent must timely enroll as provided in Sections 2.6 or 2.7.

2.2 Eligibility of Subscriber's Spouse. The Subscriber may enroll an 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 as determined by CareFirst.

2.3 Eligibility of Subscriber's Domestic Partner. The Subscriber may enroll an individual that is his or her 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 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 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 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 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 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 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 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 as determined by CareFirst.

2.4 Eligibility of Dependent Children. The Subscriber may enroll an individual that is an eligible Dependent Child. An individual who is the child of a 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.

Dependent Child means an individual who:

A. Is:

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

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

3. 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; or

4. A grandchild of the Subscriber, the Subscriber's Spouse or the Subscriber's Domestic Partner who:

a) Is unmarried; and

b) Is a dependent of the Subscriber, the Subscriber's Spouse or Domestic Partner.

B. Is under the Limiting Age of twenty-six (26); or

C. Is a child who is the subject of a Medical Child Support Order that creates or recognizes the right of the child to receive benefits under the health insurance coverage of the Subscriber, the Subscriber's covered Spouse or the Subscriber's covered Domestic Partner.

D. 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.

E. Premium changes resulting from the enrollment of a Dependent Child will be effective as determined by CareFirst.

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

C. 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. Eligible individuals may elect coverage as a Subscriber or Member, as applicable, only during an Annual Enrollment Period or a Special Enrollment Period.

A. Annual Open Enrollment. During an Annual Open Enrollment Period, an eligible individual may enroll as a Subscriber or Dependent through CareFirst.

B. Newly Eligible Subscribers. If an eligible individual is a new Eligible Student, the Eligible Student may enroll him or herself and any eligible Dependent during the time period specified by CareFirst.

C. Special Enrollment. If an eligible individual does not enroll during an Annual Open Enrollment Period or during the time period specified by CareFirst, he or she may only enroll during a Special Enrollment Period.

1. An eligible individual may enroll as a Subscriber or Dependent upon the occurrence of one of the following qualifying events:

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

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

(4) Loses coverage or eligibility rights as determined by the Academic Institution.

b) An eligible individual gains, or becomes, a Dependent through marriage, birth, adoption, placement for adoption, grant of court or testamentary guardianship or placement of a child for foster care. The foster child is not eligible for coverage under this certificate of coverage.

c) The eligible individual'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.

d) An eligible individual or his or her Dependent 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.

e) The eligible individual is determined to be newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless if the eligible

individual is already enrolled in another Qualified Health Plan.

f) The eligible individual gains access to new Qualified Health Plans as a result of a permanent move.

g) It has been determined by the Exchange that an eligible individual or enrollee, or his or her Dependents, was not enrolled in QHP coverage; was not enrolled in the QHP selected by the qualified individual or enrollee; or is eligible for but is 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 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

.h) Within 6 months after the death of a spouse, a Subscriber may exercise the addition of a Subscriber's dependent children to the Agreement if (1) the dependent children previously were covered under the spouse's plan and (2) the Subscriber's spouse has died.

2. If an eligible individual did not timely enroll during an Annual Open Enrollment Period or during the time period specified by the Academic Institution because he or she already had coverage under an employer sponsored health plan or a group health benefits plan, he or she may enroll as a Subscriber or Dependent under this Agreement due to any of the following qualifying events:

a) Death of the employee covered under the other employer sponsored plan or group health benefits plan.

b) Termination (other than by reason of such employee's gross misconduct) of the employee covered under the other employer sponsored plan or group health benefits plan.

c) The divorce or legal separation of the eligible individual from his or her Spouse who was the employee covered under the other employer sponsored plan or group health benefits plan.

d) The employee covered under the other employer sponsored plan or group health benefits plan becomes eligible for benefits under Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq.

e) The eligible individual or eligible Dependent is a dependent child who ceased to be a dependent child under the generally applicable requirements of the other employer sponsored plan or group health benefits plan.

f) The employee covered under the other employer sponsored plan or group health benefits plan lost coverage as a result of a proceeding in a case under title 11, commencing after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time. In the case of an event described in this subparagraph, "lost coverage" includes a substantial elimination of coverage with respect to a qualified beneficiary as described in 29 U.S.C. § 1167(3)(c) within one year before or after the date of the commencement of the proceeding.

D. With the exception of the qualifying events described in Section 2.6C.1. a), d) and i), the Special Enrollment Period for the qualifying events listed in Section 2.6C shall be the sixty (60) day period from the date of the qualifying event. In the case of a qualifying event under 2.6C.1.a), the Special Enrollment Period shall be the sixty (60) days before and after the loss of coverage. In the case of a qualifying event under Section 2.6C.1.d), the Special Enrollment Period shall be the sixty (60) days before and after the loss of eligibility for qualifying coverage in an employer-sponsored plan. In the case of a qualifying event under Section 2.6C.1.i), the Special Enrollment Period shall be within 6 months after the death of a spouse.

E. 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.

2. The Effective Date for an eligible individual or Dependent who gains or becomes a Dependent as described in Section C.1.b) is the 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.

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

(4) For a child placed for foster care, the date of placement of the child by the foster care agency. The foster child is not eligible for coverage under this Agreement.

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. Otherwise, the Dependent Child will not be covered beyond the first thirty-one (31) days and cannot be enrolled until the next Annual Open Enrollment Period.

3. The Effective Date for a Qualified Individual who gains or becomes a new Dependent though marriage who enrolls during a Special Enrollment Period shall be the first of the month following the receipt of enrollment by the CareFirst.

4. The Effective Date for an eligible individual who loses coverage who enrolls during a Special Enrollment Period described in 2.6C.1a) and d), 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 2.6E.5.

5. In all other cases, the Effective Date for an eligible individual who enrolls during a Special Enrollment Period will be:

   a) For enrollment received by CareFirst between the first and the fifteenth day of the month, the first day of the following month; and

   b) For enrollment received by CareFirst between the sixteenth and the last day of the month, the first day of the second following month.

6. The Effective Date for an eligible individual who becomes a newly Eligible Subscriber as described in Section B will be date determined by CareFirst.

7. Premium changes resulting from the enrollment of a Subscriber or a Dependent during a Special Enrollment Period will be effective as determined by CareFirst.

2.7 Medical Child Support Orders (MCSO).

A. Eligibility and Termination.

1. Upon receipt of an MCSO, CareFirst 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 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 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 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 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 made an administrative or clerical error in recording or reporting information.

2.9 Cooperation and Submission of Information. The Subscriber agrees to cooperate with and assist CareFirst, including providing CareFirst with reasonable access to eligibility records upon request. At any time that coverage is in effect, CareFirst reserves the right to request documentation substantiating eligibility.

Knowingly attempting to obtain, or actually obtaining eligibility for any person known to the Subscriber 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 reserves to itself any and all rights provided by law for such act or acts.

SECTION 3
PREMIUMS AND PAYMENT

3.1. Premiums. All Premiums shall be paid to CareFirst by the Academic Institution. The initial Premium is due to CareFirst on the date as determined by CareFirst. It is the obligation of the Academic Institution to remit payment to CareFirst, as such obligations are described in the Academic Institution Contract between CareFirst and the Academic Institution.

3.2 Non-Payment of Premiums. Except for the initial Premium(s), there is a grace period of 31 days within which overdue Premiums can be paid without loss of coverage. The 31-day grace period begins on the Premium Due Date. The grace period will be granted for the payment of each Premium by the Academic Institution falling due after the first Premium. This Agreement shall continue in force during the grace period.

If Premiums have not been received by the Premium Due Date, CareFirst will notify the Academic Institution in writing of the overdue Premiums. If CareFirst receives payment by the Academic Institution of all amounts listed on the notice prior to the end of the 31-day grace period, coverage will continue without interruption. If CareFirst does not receive full payment by the Academic Institution prior to the end of the grace period, the Subscriber's and any Member's coverage will terminate effective as of midnight on the last day of the grace period. No additional Premiums will be charged for the time coverage continued in force under the grace period.

3.3 Reinstatement.

A. If any Premium is not paid in full by the Academic Institution within the time granted the Academic Institution, a later acceptance of Premium in full by CareFirst or by any agent authorized by CareFirst 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 or the agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered by the Academic Institution, the Agreement will be reinstated upon approval of the application by CareFirst or, lacking approval, upon the forty-fifth (45^{th}) day following the date of the conditional receipt unless CareFirst has previously notified the Academic Institution in writing of its disapproval of the reinstatement application.

C. The Academic Institution and CareFirst 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 made by CareFirst.

3.5 Premium Rate Changes. There may be a Premium rate change when approved by the Maryland Insurance Administration, as provided by law. CareFirst will not increase the Member's Premium rate more frequently than once every Contract Year. CareFirst will provide notice of an approved Premium rate change by giving the Academic Institution 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 the effective date each Contract Year when this Agreement renews.

CareFirst may change the Premium during a Contract Year if the change is due solely to a mistake impacting the Premium rate or due to the enrollment or termination of a Dependent.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Agreement. Coverage for a Subscriber will end on the first of these to occur:

A. The termination date of this Agreement pending the premium has been paid in full by the Academic Institution;

B. The last day of the semester of which the Subscriber remains eligible and that premium has been paid for by the Academic Institution; or

C. The last day of the semester in which the Subscriber withdraws from the Academic Institution because of entering the armed forces of any country. Premiums will be refunded; on a pro-rata basis, as applicable, when application is made within ninety (90) days from withdrawal;

The Subscriber may terminate the Agreement by notifying the Academic Institution and the Academic Institution may terminate the Subscriber's coverage under this Agreement. The Academic Institution must provide written notification of any such termination to CareFirst. Termination shall be without prejudice to any claim originating prior to the effective date of the cancellation. Following receipt of the written notice of termination from the Academic Institution, the date of the termination will be the last day of the respective semester during the Contract Year that Premium was paid by the Academic Institution.

4.2 CareFirst Right to Terminate Coverage. CareFirst may cancel or refuse to renew this Agreement, or terminate the coverage of a Member.

A. Termination of Subscriber's Enrollment at the Academic Institution:

1. If the Subscriber is no longer an Eligible Student because he or she withdraws their own candidacy or their candidacy is terminated by the Academic Institution prior to the end of the first semester of the Contract Year and the Premium has been paid in full for the first semester by the Academic Institution, the Member will continue to receive coverage under this Agreement up to December 31st of the Contract Year.

2. If the Subscriber is no longer an Eligible Student because he or she withdraws their own candidacy or their candidacy is terminated by the Academic Institution after completion of the first semester and prior to the end of the second semester of the Contract Year, and the Premium has been paid in full for the second semester by the Academic Institution, the Member will continue to receive coverage under this Agreement up to May 31st of the Contract Year.

If the Subscriber is no longer an Eligible Student because he or she withdraws their own candidacy or their candidacy is terminated by the Academic Institution at the end of the second semester, but prior to the end of the Contract Year, and the Premium has been paid in full for the Contract Year by the Academic Institution, the Member will continue to receive coverage under this Agreement up to the end of the Contract Year.

B. Termination of Dependent Coverage:

1. For all Dependents, coverage will terminate on the same date that coverage terminates for the Subscriber.

2. Except for a Dependent Child reaching the Limiting Age, a Dependent's coverage will terminate at the end of the semester in which the Dependent became no longer eligible if there is a change in their status or relationship to the Subscriber, such that they no longer meet the eligibility requirements of this Agreement.

3. For a Dependent Child reaching the Limiting Age, coverage will terminate at the end of the semester in which the Dependent reaches the Limiting Age.

The Subscriber is responsible for notifying the Academic Institution of any changes in the status of a Dependent which affects his or her eligibility for coverage under this Agreement, and the Academic Institution will notify CareFirst. These changes include a death or divorce. If the Subscriber does not notify the Academic Institution of these types of changes and it is later determined that a Dependent was not eligible for coverage, CareFirst may rescind the Agreement and recover the full value of the services and benefits provided during the period of ineligibility if fraud or intentional misrepresentation was involved in the failure to provide notification of any changes in the status of a Dependent which affects his or her eligibility under this Agreement.

C. CareFirst elects not to renew all of its individual health benefit plans in the state or jurisdiction. In this case, CareFirst:

1. Shall give notice of this decision to all affected individuals at least one hundred eighty (180) days before the effective date of non-renewal; and

2. Shall give notice to all affected individuals at least one hundred eighty (180) days before the effective date of non-renewal of the individual's option to purchase all other individual health benefit plans currently offered by an affiliate of CareFirst.

4.3 Rescission of Enrollment for Fraud or Misrepresentation. This Agreement, or the enrollment of a Member, may be Rescinded if:

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

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

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

CareFirst will provide thirty (30) days advance written notice of any Rescission. CareFirst shall have the burden of persuasion that its Rescission complies with applicable 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 performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of material fact. The Subscriber will be responsible for payment of any voided benefits paid by CareFirst, net of applicable Premiums paid.

4.4 Cancellation of Dependent Coverage by the Subscriber.

A. Except as provided in paragraph 4.4B, the Subscriber may terminate the coverage of an eligible Dependent. The effective date of the termination will be the end of the semester of the receipt by CareFirst of the notice of termination from the Academic Institution. If coverage is terminated under this Section, CareFirst will not be required to give notice of termination to the Subscriber or to the Dependents.

B. If a Dependent Child is enrolled under this Agreement pursuant to a MCSO, as described in Section 2.7, the Subscriber may not terminate or cancel the coverage of such child except as specifically provided in Section 2.7.

C. If coverage is canceled under this paragraph, CareFirst will not be required to give the Subscriber notice of termination.

4.5 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.

4.6 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 Agreement will terminate on the last day of the semester during which the Subscriber's death occurred.

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 semester during which the Subscriber's death occurred.

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

4.7 Effect of Termination. Except as provided in Sections 4.8, 4.9 and 4.10, 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.

4.8 Extension of Benefits - Covered Services.

A. Eligibility for Extension of Benefits.

1. 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:

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

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

2. If a Member is Totally Disabled when his/her coverage terminated, CareFirst shall continue to pay benefits for Covered Services in effect at the time the Member's coverage terminates, for expenses incurred by the Member for the condition causing the disability until the earlier of:

a) The date the Member ceases to be Totally Disabled; or

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

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

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

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

C. This provision does not apply if:

1. Coverage is terminated because an Academic Institution 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.

4.9 Extension of Benefits - Covered Dental Services.

A. CareFirst 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 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 Academic Institution 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.

4.10 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 Section, a Premium may not be charged. This provision does not apply if:

A. Coverage is terminated because an Academic Institution 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.

4.11 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 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 Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:

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

b) May be reduced when, under the order of determination rules, another Plan determines its benefits first. The 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 Plan is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst Plan means this 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. Hospital indemnity coverage benefits or other fixed indemnity coverage;

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

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

7. Accident only coverage;

8. Benefits provided for long-term care insurance policies for non-medical services; or

9. Medicare supplement policies.

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

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

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

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

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

C. Order of Benefit Determination Rules.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If there is no court decree setting out the responsibility

for the child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:

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

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

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

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

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

(4) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph C.2.e) below applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Paragraph C.2.b)(1) to the dependent child's parent(s) and the dependent's spouse.

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

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

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

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

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

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

D. Effect on the Benefits of this CareFirst Plan.

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

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

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

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

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

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

2. Insurance companies; or

3. Other organizations.

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

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

2. If a Medicare-eligible Member has not enrolled in Medicare Part A and/or Part B, CareFirst 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 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 has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. This right applies to the amount of benefits paid by CareFirst for injuries or illnesses where a third party could be liable.

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

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

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

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

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

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

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

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

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

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

SECTION 6
GENERAL PROVISIONS

6.1 Entire Agreement; Changes. The entire agreement between CareFirst and the Academic Institution includes: (a) the Academic Institution Contract; (b) the Student Health Plan Individual Enrollment Agreement; (c) the Benefit Determination and Appeal and Grievance Procedures Attachment (d) the Description of Covered Services; (e) Schedule of Benefits; and (f) 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. Any duly authorized notice, amendment or rider will be issued by CareFirst 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. Claim 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 shall provide claim forms for filing proof of loss to each claimant. If CareFirst does not provide the claim forms within fifteen (15) days after notice of claim is received, the claimant is deemed to have complied with the requirements of the policy as to proof of loss if the claimant submits, within the time fixed in the policy for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

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

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

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

3. Provide benefits directly to:

   a) The non-insuring, custodial parent;

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

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

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

For Covered Services, Covered Dental Services or Covered Vision Services provided by Non-Participating 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 within one (1) year after the date of the loss. Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

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

C. Time of Payment of Claims. Benefits payable will be paid not more than thirty (30) days after receipt of written proof of loss. 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 makes a claim payment to a Member or a Provider on behalf of the Member in error, the overpaid Member or Provider is required to repay CareFirst the amount that was overpaid in error. If the Member or Provider who was overpaid has not repaid the full amount owed CareFirst and CareFirst makes a subsequent benefit payment to this Member or to the same Provider, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

E. Payment of Claims - Covered Medical Services. Payment for Covered Services rendered by a Preferred Provider will be paid directly to the Preferred Provider rendering the services. Direct payments will also be made by CareFirst to providers from the United States Department of Defense and the United States Department of Veteran Affairs.

If a Member makes an Assignment of Benefits for services rendered by a Non-Preferred Provider who is a physician, a Hospital-Based Physician, an On-Call Physician, or an Ambulance Service Provider, payment for services will be paid directly to the Non-Preferred Provider who is a physician, a Hospital-Based Physician, an On-Call Physician or an Ambulance Service Provider except as provided in Section 6.3C. If a Member receives Covered Services from any other provider other than a Non-Preferred Provider who is a physician, a Hospital-Based Physician, an On-Call Physician or an Ambulance Service Provider who accepts an Assignment of Benefits, CareFirst reserves the right to pay either the Member or the provider. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Preferred Provider. In any event, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and, unless the fee is negotiated, for any Balance Bill from a Non-Preferred Provider who is not a Hospital-Based Physician, an On-Call Physician, or an Ambulance Service Provider who accepts an Assignment of Benefits.

F. Payment of Claims - Covered Dental Services. Payments for Covered Dental Services rendered by Preferred or Participating Dentists will be paid directly to Preferred or Participating Dentists or to their representatives.

If a Member makes an Assignment of Benefits for services rendered by a Non-Participating Dentist who is a physician, payment for services will be paid directly to the Non-Participating Dentist who is a physician, except as provided in Section 6.3C. If a Member receives Covered Dental Services from any other Non-Participating Dentist other than a physician who accepts an Assignment of Benefits, CareFirst reserves the right to pay either the Member or the provider. It is the Member's responsibility to apply any CareFirst payments received to the claim from the Non-Participating Dentist. In any

event, the Member is responsible for any applicable Deductible or Coinsurance amounts stated in the Schedule of Benefits and for any Balance Bill.

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.

If a Member makes an Assignment of Benefits for services rendered by a Non-Contracting Vision Provider who is a physician, payment for services will be paid directly to the Non-Contracting Vision Provider who is a physician, except as provided in Section 6.3C. If a Member receives Covered Vision Services from any other Non-Contracting Vision Provider other than a physician who accepts an Assignment of Benefits, the Vision Care Designee reserves the right to pay either the Member or the provider. It is the Member's responsibility to apply any Vision Care Designee payments received to the claim from the Non-Contracting Vision Provider. In any event, the Member is responsible for any Balance Bill.

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 or its designee for reimbursement. Members will be entitled to reimbursement up to the Prescription Drug Allowed Benefit from CareFirst or its designee, minus any applicable Deductible, Copayment or Coinsurance. The Member is responsible for any balances above the Prescription Drug Allowed Benefit.

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 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 a Member may:

A. Make an Assignment of Benefits to a physician who is a Non-Preferred Provider, a Non-Participating Dentist, or a Non-Contracting Vision Provider, or to an On-Call Physician, a Hospital Based Physician or an Ambulance Service Provider who accepts an Assignment of Benefits;

B. Assign any other benefits or payments under the Agreement only as specifically provided by this Agreement or required by law; or

C. Notwithstanding any permitted and valid Assignment of Benefits, CareFirst or the Vision Care Designee may refuse to directly reimburse the Non-Preferred Provider, Non-Participating Dentist, Non-Contracting Vision Provider, On-Call Physician, Hospital Based Physician or Ambulance Service Provider if:

1. CareFirst or the Vision Care Designee receives notice of the Assignment of Benefits after the time that it has paid the benefits to the Member;

2. CareFirst or the Vision Care Designee, due to an inadvertent administrative error, has previously paid the Member;

3. The Member withdraws the Assignment of Benefits before CareFirst or the Vision Care Designee has paid the Non-Preferred Provider, Non-Participating Dentist, Non-Contracting Vision Provider, On-Call Physician, Hospital Based Physician or Ambulance Service Provider; or

4. The Member paid the Non-Preferred Provider, Non-Participating Dentist, Non-Contracting Vision Provider, On-Call Physician, Hospital Based Physician or Ambulance Service Provider the full amount due at the time of service.

6.4 Legal Actions. A Member cannot bring any lawsuit against CareFirst 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.

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

6.6 Identification Card. Any 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 permission to obtain and use such records and information, including medical records and information requested to assist CareFirst in determining benefits and eligibility of Members.

6.8 Physical Examinations. CareFirst 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 will be performed at the expense of CareFirst.

6.9 Member Privacy. CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable financial, medical or health related data. In that regard, CareFirst will not provide to unauthorized third parties any personally identifiable financial or medical information without the prior written authorization of the Member or parent/guardian of the Member or as otherwise permitted by law. Personal information, including email addresses and phone numbers, may be used and shared with other businesses who work with CareFirst to administer and/or provide benefits under this plan. Personal information 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's Relationship to Providers. Health care providers, including Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers, are independent contractors or organizations and are related to CareFirst by contract only. Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and

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

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

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

6.13 Rights to Vest in Guarantor. In the event of insolvency, CareFirst'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 is obligated to make available.

6.14 Records and Clerical Errors.

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

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

6.15 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. The Academic Institution and the Members consent to Maryland jurisdiction for all actions arising from this Agreement.

6.16 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 the Academic Institution 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 Academic Institution or Member; and

2. A copy of the statement is given to the Academic Institution 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.

6.17 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 Academic Institution on behalf of the Subscriber shall pay CareFirst the increased Premium due by the next Premium Due Date after notification by CareFirst. If, due to the correction in the Member's age, the Academic Institution on behalf of a Subscriber has paid a Premium, or portion of a Premium, not due, CareFirst'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. 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'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 based on the Member's misstated age.

6.18 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.

6.19 Notices.

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

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

CareFirst of Maryland, Inc.
10455 Mill Run Circle
Owings Mills, MD 21117-5559

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

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

6.20 Notice of Address Change. The Subscriber must notify CareFirst 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 is only responsible for mailing notices or correspondence to the last known physical address or e-mail address of the Subscriber.

6.21 Uniform Modification. CareFirst 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).

6.22 Amendment Procedure. Except for Premium rate changes, CareFirst will amend this Agreement to implement modifications made pursuant to Section 6.21 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 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, has the authority to waive any conditions or restrictions of the Agreement or to bind CareFirst by making any promise or representation or by giving or receiving any information. No change in the Agreement will be binding on CareFirst, unless evidenced by an amendment signed by an authorized representative of CareFirst

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

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

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, Maryland 21117-5559

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

An independent licensee of the BlueCross and BlueShield Association

ATTACHMENT A

BENEFIT DETERMINATION AND APPEAL AND GRIEVANCE PROCEDURES

This attachment contains certain terms that have a specific meaning as used herein. These terms are capitalized and defined in Section A below, and/or in the 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 a 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 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 attachment, 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 attachment, 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.

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

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

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

Relevant. A document, record, or other information shall be considered Relevant to a 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 attachment; 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, 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. 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 or 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. 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, as applicable. 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.

CareFirst of Maryland, Inc.

Chester E. Burrell
President and Chief Executive Officer

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, Maryland 21117-5559

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

An independent licensee of the Blue Cross and Blue Shield Association.

ATTACHMENT B
DESCRIPTION OF COVERED SERVICES - STUDENT HEALTH PLAN

The services described herein are eligible for coverage under the Agreement. CareFirst will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services incurred by a Member, including any extension of benefits for which the Member is eligible.

It is important to refer to the Schedule of Benefits to determine the percentage of the Allowed Benefit that CareFirst will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists important information about Deductibles, the Out-of- Pocket Maximum and other features that affect Member coverage, including specific benefit limitations.

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

CareFirst of Maryland, Inc.

Chester E. Burrell
President and Chief Executive Officer

SECTION 1
OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES

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 providers and Specialists.

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,

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

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

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

Benefits for preventive care include the following:

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

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.

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

4. Breast Cancer Screening. 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 childhood obesity.

5. Limitations. Benefits for the treatment of obesity are limited to Members under age nineteen (19). Benefits for preventive care and screening for obesity are available to all Members.

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. In addition, 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 approved facility;

c) Inpatient care for delivery;

d) Coverage for care rendered at a CareFirst 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 provision is not applicable to a Child-Only Agreement.

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,

(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.

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 functional 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 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 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-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 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. For Members from birth to Age 19.

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

2. 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. Oral chemotherapy; and 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 therapeutic and chemotherapeutic agents, medication and nutrients, enteral nutrition into the gastrointestinal tract, and prescription medications;

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. 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;

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; and,

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.

6. Prior authorization has been obtained from CareFirst.

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.

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

A. Accidental Injury.

1. Covered Benefits. Dental benefits will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if the injury did not arise while or as a result of biting or chewing, and treatment is commenced within six (6) months of the injury or, if due to the nature of the injury, treatment could not begin within six (6) months of the injury, treatment began within six (6) months of the earliest date that it would be medically appropriate to begin such treatment.

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.

1.16 Oral Surgery.

A. Benefits for oral surgery include:

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

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

B. Medically Necessary surgical treatment, as determined by CareFirst, 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.

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

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 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. 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.

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 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 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 per provider.
2. Routine cleaning of teeth (dental prophylaxis).
3. Topical application of fluoride.
4. Bitewing x-ray (not taken on the same date as those in 2.2C below) per provider.
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 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 per provider.
2. One cephalometric x-ray.

D. Services limited to once per tooth per 60 months: sealants on permanent molars.

E. Services limited to once per quadrant per 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 12 months, per tooth, per surface.

3. Direct pulp caps and indirect pulp caps.

B. Non-surgical periodontic services limited to:

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

2. Provision splinting, intracoronal and extracoronal.

3. Full mouth debridement to enable comprehensive periodontal procedure limited to one per 24 months.

4. Periodontal maintenance procedures limited to two per 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 treatment per 24 months per Member per quadrant or per tooth, and limited to two quadrants per 12 months.

2. Osseous surgery (including flap entry and closure) limited to one treatment per 24 months per Member per quadrant.

3. Mucogingival surgery limited to grafts and plastic procedures; one 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 once per tooth per lifetime per Member.

C. Oral surgical services as required.

1. Simple and surgical extractions, including impactions, limited to 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 per 60 months per tooth.

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

3. Stainless steel crowns.

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

B. Dentures

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

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

3. Pre-operative radiographs required.

4. Pre-treatment estimate, as described in Section 15.3F, 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. Adjustment to maxillofacial prosthetic appliance, by report, limited to one per 6 months, per Member.

8. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, limited to one per 6 months, per Member, per arch.

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

D. Repair of prosthetic appliances, including removable dentures, full and/or partial.

E. Occlusal guard, by report, limited to one per 24 months, per Member

F. Fabrication of athletic mouth guard limited to one per 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)by CareFirst, as described in Section 15.3F, Estimate of Eligible Benefits. The following documentation must be submitted with the request for 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 PTE is obtained:

1. Retainers:

   a) One set (included in comprehensive orthodontics);

   b) Replacement allowed one per arch per lifetime within 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 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 24 periodic orthodontic treatment visits).

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

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

SECTION 3
PEDIATRIC VISION SERVICES

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

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

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

B. Frames and Spectacle Lenses or Contact Lenses

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

a) Measurement of face and interpupillary distance;

b) Quality assurance; and

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

2. One pair of frames per Benefit Period; and

3. One pair of prescription spectacle lenses per Benefit Period

a) Spectacle lenses include choice of glass or plastic lenses 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 pair of elective prescription contact lenses per Benefit Period; or,

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

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

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

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

C. Low vision services, including one comprehensive Low Vision evaluation every 5 years, 4 follow-up visits in any 5-year period and prescribed 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 for low vision services. Contracting Vision Providers will obtain the necessary prior authorization for these services.

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

3.3 Limitations. Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year. Benefits for treatment of medical conditions of the eye are covered under Section 1. Benefits will not be provided for add-ons to basic spectacle lenses. Non-collection frames and non-collection contact lenses are not covered under this Agreement when obtained from a Contracting Provider.

SECTION 4
ADULT VISION SERVICES

4.1 Covered 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

5.1 Covered Inpatient Hospital Services. A Member will receive benefits for Covered Services listed below when admitted to a hospital. Coverage of inpatient hospital services is subject to certification by Utilization Management for Medical Necessity. Except for maternity and Emergency admissions, prior authorization is required. Benefits are provided for:

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

B. Physician and Medical Services. 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, 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, 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;

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 in the Individual Enrollment Agreement describes the steps, if any, necessary to enroll a newborn Dependent Child. The non-routine care of the newborn 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. Except for cornea transplants and kidney transplants, prior authorization must be obtained from CareFirst.

B. Covered services include the following:

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

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

3. 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 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.

SECTION 6
SKILLED NURSING FACILITY SERVICES

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;

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

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

A. The admission to the Skilled Nursing Facility must be a substitute for hospital care (i.e., if the Member were not admitted to a Skilled Nursing Facility, he or she would have to be admitted to a hospital).

B. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.

C. The Member must require Skilled Nursing Care or skilled rehabilitation services which are:

1. Required on a daily basis;

2. Not Custodial; and,

3. Only provided on an inpatient basis.

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

A. A Member cannot self-administer the care;

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

C. Ordered by a physician;

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

E. Covered by Medicare.

SECTION 7
HOME HEALTH CARE SERVICES

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 as Medically Necessary.

D. Prior authorization 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. Prior authorization has been obtained from CareFirst.

7.3 Additional Home Health Care Benefits.

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

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

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

3. 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 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 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

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. Coverage for hospice care services is subject to certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements. 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;

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;

K. Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Member.

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

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

B. The Member's attending physician must submit a written hospice care services Plan of Treatment to CareFirst;

C. The Member must meet the criteria of the Qualified Hospice Care Program;

D. Prior authorization has been obtained from CareFirst.

E. The need and continued appropriateness of hospice care services must be certified by CareFirst as meeting the criteria for coverage in accordance with CareFirst utilization management requirements.

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 in advance to request an extension of benefits. CareFirst reserves the right to extend the eligibility period on an individual case basis if CareFirst determines that the Member's prognosis and continued need for services are consistent with a program of hospice care services.

SECTION 9
INPATIENT AND OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

9.1 Professional Services. Professional services rendered by licensed, registered or certified professional mental health and substance abuse practitioners when acting within the scope of his/her license, registration or certification, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.

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, individual and group therapy visits);

5. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;

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, registered or certified 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 will only cover the hospital's average charge for semiprivate accommodations.

2. General nursing care;

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 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

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.

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 in order to obtain reimbursement for Emergency Services or Urgent Care.

10.2 Notice to CareFirst in the Event of an Emergency.

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

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

2. Within 48 hours after first receiving the care.

B. If it was not reasonably possible to give notice, this requirement will be met if notice was given as soon as reasonably possible. The Member must provide information about the Emergency Medical Condition and the care received.

10.3 Ambulance Services.

A. Benefits are available for Medically Necessary air transportation and ground ambulance 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 Filing a Claim for a Non-Preferred Provider. When a Member receives Emergency Services or Urgent Care from a Non-Preferred Provider, the Member must follow the proof of loss requirements of Section 6.2B of the Individual Enrollment Agreement.

SECTION 11
MEDICAL DEVICES AND SUPPLIES

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 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.

11.3 Benefit Limits. Benefits for a Medical Device will be limited to the lesser of purchase price of the item or the Allowed Benefit for 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 will pay an amount that does not exceed CareFirst'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.

11.4 Responsibility of CareFirst. CareFirst will not be liable for any claim, injury, demand, or judgment based on tort or other grounds (including warranty of equipment), arising out of or in connection with the rental, sale, use, maintenance, or repair of prosthetic devices, corrective appliances or durable medical equipment, whether or not 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 the dispensing amount for non-Maintenance Drugs Maintenance Drugs stated in the Schedule of Benefits.

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

Qualifying Individual, as used in this provision, means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the 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-approved health care provider who has elected to participate in the PCMH.

SECTION 14
GENERAL PROVISIONS

14.1 How the Plan Works**.** The Preferred Provider Plan offers two levels of benefits. A Member may select the benefit level at which coverage will be provided each time care is sought. Under the Preferred Provider Plan, the Member may receive benefits for a particular service under either the in-network component or the out-of-network component. A Member may not receive duplicate benefits for the same services.

A. In-Network Benefits. When in-network benefits apply, Members are eligible for a higher level of benefits than when a provider other than those stated in this Section is used. In-network benefits apply in the following instances:

1. Services Rendered by a Preferred Provider, Preferred Dentist, Contracting Pharmacy Provider or Contracting Vision Provider. When Members use a Preferred Provider, Preferred Dentist, Contracting Pharmacy Provider or Contracting Vision Provider, benefits are based on the Allowed Benefit for that type of service. The level of benefits is reflected in the Schedule of Benefits. A Preferred Provider, Preferred Dentist, Contracting Pharmacy Provider or Contracting Vision Provider will submit claims directly to CareFirst for Covered Services, Covered Dental Services and Covered Vision Services.

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

   a) CareFirst 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 cannot provide reasonable access to a Preferred 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.

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

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

B. Out-of-Network Benefits.

1. Except for Emergency Services, out-of-network benefits apply when Covered Services, Covered Dental Services or Covered Vision Services are provided by a Non-Preferred Provider, Non-Preferred Dentist, Non-Contracting Vision Provider or non-Contracting Pharmacy Provider or in a circumstance not addressed in Section 14.1A or 14.3E. When a Member uses a provider that is not a Preferred Provider, Preferred Dentist, Contracting Pharmacy Provider or Contracting Vision Provider, benefits are based on the appropriate Allowed

Benefit. The level of benefits is shown in the Schedule of Benefits. The Member will be responsible for any applicable Deductible, Copayments or Coinsurance. Except for Covered Dental Services rendered by a Participating Dentist or if the Member makes an Assignment of Benefits for services rendered by a Non-Preferred Provider who is a physician and who is a Hospital-Based Physician, an On-Call Physician, or by an Ambulance Service Provider, the Member will be responsible for any Balance Bill from a Non-Preferred Provider, a Non-Participating Dentist, a Non-Contracting Vision Provider or a non-Contracting Pharmacy Provider unless the fee is negotiated. If the fee is negotiated the Member will not be responsible for any Balance Bill.

2. Member Responsibilities.

a) Members are required to submit claims for Covered Services, Covered Dental Services and Covered Vision Services rendered by Non-Preferred Providers, Non-Participating Dentists Non-Contracting Vision Providers and non-Contracting Pharmacy Providers . Members may have claims submitted by a Non-Preferred Provider, a Non-Participating Dentist a Non- Contracting Vision Provider or a non-Contracting Pharmacy Provider on their behalf. A claim submitted by a Non-Preferred Provider, Non-Participating Dentist, and Non- Contracting Vision Provider on behalf of a Member must be submitted within the time frame granted to the Member to file the claim. Refer to Section 6.2 of the Individual Enrollment Agreement for claims submission requirements and Section 6.3 of the Individual Enrollment Agreement for the Member's ability to make an Assignment of Benefits to certain providers.

b) Covered Services or Covered Vision Services may require prior authorization. Please see Section 16, Utilization Management Requirements, for a description of the utilization management/prior authorization requirements and the Covered Services and Covered Vision Services that require prior authorization. Section 15.3 states when the Member is responsible to obtain prior authorization for a Covered Service or Covered Vision Service that requires it. As stated in Section 14.3F, the Member is required in all circumstances to obtain and submit to CareFirst the required pre-treatment estimate for orthodontic services obtained from a Preferred Dentist, a Participating Dentist or a Non-Participating Dentist.

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

A. An individual who is not an Eligible Provider; or,

B. The Member himself/herself, or by the Member's Spouse, mother, father, daughter, son, brother, or sister.

14.3 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 related to any Covered Dental Service, the case in question will be submitted to the CareFirst 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 CareFirst as stated in the Schedule of Benefits. Benefits for Covered Dental Services rendered by Participating Dentists and Non-Participating Dentists will be provided by CareFirst 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. CareFirst makes payment for Covered Dental Services, but does not provide these services. CareFirst is not liable for any act or omission of any Dentist.

E. Referral to a 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 Non-Participating Dentist if the Member is diagnosed with a condition or disease that requires specialized dental care; and

1. CareFirst does not contract with a Dental Specialist with the professional training and expertise to treat the condition or disease; or,

2. CareFirst cannot provide reasonable access to 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, CareFirst will treat the services rendered by the Dental Specialist as if the services were provided by a Preferred Dentist who is a Dental Specialist. The Member is 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 CareFirst 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).

CareFirst encourages a Member to obtain a written Estimate of Eligible Benefits (CareFirst's written estimate of benefits before a service is rendered) also known as a pre-treatment estimate (PTE) for major dental procedures, thereby alerting a Member of the out-of-pocket expenses that may be associated with the treatment plan, related deductibles, co-insurance and/or procedures that are not Covered Dental Services. Based on an Estimate of Eligible Benefits or PTE from CareFirst, a Member can decide whether or not to incur the expense that may be associated with a particular treatment plan.

Failure to obtain an Estimate of Eligible Benefits or PTE has no effect on the benefits to which a Member is entitled 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 CareFirst. Should the review determine that the service(s) rendered meet CareFirst's criteria for benefits, the benefits will be provided as described in this Agreement. However, should the review of the claim determine that the treatment or procedure(s) did not meet CareFirst's criteria for benefits, benefits will not be provided.

To request an Estimate of Eligible Benefits or PTE prior to receiving dental treatment or dental procedures, a Member should contact his or her Dentist who will coordinate the request on the Member's behalf. If the Dentist has any questions about the process, he or she may contact the CareFirst Provider Services Department or go to the CareFirst website at www.carefirst.com, which lists information in the Physicians and Providers section, under the subsection for Dental, and list of Resources. The Estimate of Eligible Benefits or PTE is merely an estimate, and it cannot be considered a guarantee of the Member's benefits or enrollment 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 CareFirst for evaluation and confirmation of the assessment score. If the score meets or exceeds the baseline requirement, the orthodontics will be approved for the Member. If the score is less than the minimal required score, then the request for orthodontic benefits will be denied.

A decision by CareFirst to deny benefits as described in this section constitutes an Adverse Decision as defined in the Agreement if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

14.4 Pediatric and Adult Vision Coverage.

A. When the Member receives a vision examination and 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 not covered under this Agreement when obtained from a Contracting Vision Provider.

3. Medically Necessary Contact Lenses are covered. When Medically Necessary Contact Lenses are obtained from a Contracting Vision Provider, the benefit payment is accepted as payment in full.

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.

Add-ons to basic spectacle lenses are not covered under this Agreement when received from a Non-Contracting Vision Provider. 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 Allowed Benefit. The Member is responsible for any difference between the amount billed and the Vision Care Designee's payment. To determine if the Member resides in a limited access area, the Member must call the Vision Care Designee at the telephone number on the Member's identification card.

14.5 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 or its designee for reimbursement. In cases of Emergency Services, Members will be entitled to reimbursement from CareFirst or its designee up to the amount of the total charge, minus any applicable Deductible, Copayment or Coinsurance. In all other cases, the Member is responsible for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits and for any Balance Bill.

3. Members have the option of ordering Prescription Drugs via mail order. The mail order program provides its Member's with a Contracting Pharmacy Provider that has an agreement with CareFirst 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 and 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 on the Prescription Guidelines. A copy of the Prescription Guidelines are 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.

4. Except for 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 on the Prescription Guidelines when obtained from a Non-Contracting Pharmacy Provider by calling the customer service telephone number listed on the identification card.

14.6 Payment Practices for Multiple Provider Participation in a Surgical Procedure. If a surgical procedure is performed by two or more surgeons, CareFirst will review the procedures to determine the benefits provided and apply all applicable reimbursement policies, as follows:

A. If the procedure is a Team Surgery, CareFirst will determine and provide the percentage of the Allowed Benefit for the surgical procedure apportioned to each surgeon of the team. This apportionment is based on several factors, including, but not limited to: the complexity of the individual surgical services performed; the amount of involvement in the operating room; the amount of pre- and post-operative care required; and whether the procedures performed are related or incidental to each other.

B. If the procedure is a Co-Surgery, the Allowed Benefit for the surgical procedure is divided equally between the co-surgeons participating in the Co-Surgery.

C. If the procedure requires a Surgical Assistant, the Allowed Benefit for Surgical Assistant services is an amount equal to 20% of the Allowed Benefit for the Covered Services provided by the operating surgeon(s) for a single procedure, and 10% of the Allowed Benefit for the Covered Services for each subsequent procedure.

1. Benefits are provided for surgical assistance performed by a physician assistant, registered nurse first assistant, nurse midwife, or nurse practitioner who is employed by the billing surgeon or directly contracted with CareFirst. Benefits are not provided for surgical assistance performed by unlicensed individuals, including but not limited to, surgical technicians and certified surgical assistants.

2. Benefits are not provided for surgical assistance performed by physician assistants, registered nurse first assistants, nurse midwives, or nurse practitioners who are employed by a facility. Benefits are not provided for surgical assistance directly to physician assistants or registered nurse first assistants.

14.7 Transitioning of Care from Member's Prior Carrier.

A. Prior Authorization. For Members transitioning care from the Member's immediate prior carrier to CareFirst:

1. At the request of the Member, the Member's parent, guardian or designee, or the Member's provider, CareFirst will accept a prior authorization from the Member's prior carrier for the procedures, treatments, medications or services which are Covered Services 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 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; 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-Preferred 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 will allow a Member to continue to receive Covered Services rendered by a Non-Preferred Provider or Covered Dental Services from a Non-Participating Dentist at the time of the Member's transition to coverage by CareFirst.

2. Continuing treatment with a Non-Preferred 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 and the Non-Preferred 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-Preferred 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 will treat the services rendered by the Non-Preferred Provider or Non-Participating Dentist as if the service was provided by a Preferred Provider or Preferred Dentist.. The Member is not responsible for the difference between the Allowed Benefit paid to a Preferred Provider or the Pediatric Dental Allowed Benefit paid to a Preferred Dentist and the charge by a Non-Preferred Provider or Non-Participating Dentist if the Non-Preferred Provider or Non-Participating Dentist accepts the Allowed Benefit paid to a Preferred Provider or the Pediatric Dental Allowed Benefit paid to a Preferred Dentist as payment in full or the Non-Preferred Provider or Non-Participating Dentist agrees to an alternative payment amount from CareFirst.

5. If the Non-Preferred Provider does not accept the Allowed Benefit paid to a Preferred Provider or the Non-Participating Dentist does not accept the Pediatric Dental Allowed Benefit paid to a Preferred Dentist and CareFirst cannot reach an agreement with the Non-Preferred Provider concerning payment for Covered Services or the Non-Participating Dentist concerning the payment for Covered Dental Services:

a) The Non-Preferred Provider is not required to continue to provide Covered Services or the Non-Participating Dentist is not required to continue to provide the Covered Dental Services.

b) If the Non-Preferred Provider accepts the Member's Assignment of Benefits, the Non-Preferred Provider may Balance Bill the Member for the difference between the Allowed Benefit paid to a Preferred Provider and the charge by a Non-Preferred Provider. 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-Preferred Provider or Non-Participating Dentist, CareFirst will facilitate transfer of care of the Member to a Preferred Provider or Preferred Dentist.

SECTION 15
UTILIZATION MANAGEMENT REQUIREMENTS

Failure to meet the requirements of the utilization management program stated in this section may result in a reduction or denial of benefits even if the services are Medically Necessary.

15.1 Utilization Management. Benefits are subject to review and approval under utilization management requirements established by CareFirst. Through utilization management, CareFirst will:

A. Review Member care and evaluate requests for approval of coverage in order to determine the Medical Necessity for the services;

B. Review the appropriateness of the hospital or facility requested; and,

C. Determine the approved length of confinement or course of treatment in accordance with CareFirst established criteria.

In addition, utilization management may include additional aspects such as prior authorization, and/or preadmission testing requirements, concurrent review, and discharge planning. Failure or refusal of the Member to comply with notice requirements and other utilization management authorization and approval procedures may result in a significant reduction in or exclusion of benefits. If coverage is reduced or excluded for failure to comply with utilization management requirements, the reduction or exclusion may be applied to all services (other than Medically Necessary inpatient Ancillary Services) related to the treatment, admission, or portion of the admission for which utilization management requirements were not met. The terms that apply to a Member's coverage for failure to comply with utilization management requirements are stated in the Schedule of Benefits.

15.2 Preferred Provider Responsibility.

A. Within the CareFirst Service Area, prior authorization will be obtained by Preferred Providers, Contracting Vision Providers and Contracting Pharmacy Providers. These providers are also responsible for providing utilization management notices and obtaining necessary utilization management approvals on the Member's behalf for services that require prior authorization. However, the Member must advise the Preferred Provider that such coverage exists. If the Preferred Provider, Contracting Vision Provider or Contracting Pharmacy Provider fails to obtain prior authorization, the Member shall be held harmless.

B. Outside of the CareFirst Service Area, a Preferred Provider under the Inter-Plan Arrangements Disclosure Amendment will obtain prior authorization for hospital inpatient services, inpatient mental health and Substance Abuse services, Skilled Nursing Facility Services and inpatient hospice care services only. In all other instances, the Member is responsible for obtaining prior authorization for Covered Services or Covered Vision Services outside of the Service Area. As stated in Section 14.3F, the Member is also required to obtain and submit to CareFirst the required pre-treatment estimate for orthodontic services obtained outside of the Service Area.

15.3 Member Responsibility. Except as provided in Section 15.2B above, the Member is responsible for obtaining all required prior authorizations for Covered Services or Covered Vision Services rendered by Non-Participating Providers or Non-Contracting Vision Providers. As stated in Section 14.3F, the Member is also required to obtain and submit to CareFirst the required pre-treatment estimate for orthodontic services obtained from a Preferred Dentist, a Participating Dentist or a Non-Participating Dentist. It is the Member's responsibility to ensure that providers associated with the Member's care cooperate with utilization management requirements. This includes initial notification in a timely manner, responding to CareFirst inquiries and, if requested, allowing CareFirst representatives to review medical records on-site or in CareFirst offices. If CareFirst is unable to conduct utilization reviews, Member benefits may be reduced or excluded from coverage.

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

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

15.5 Services Subject to Utilization Management. Preferred Providers, Contracting Vision Providers and Contracting Pharmacy Providers are responsible for obtaining necessary utilization management approvals on the Member's behalf for services that require prior authorization. It is the Member's responsibility to obtain prior authorization when services are rendered outside of the CareFirst Service Area and for services rendered by Non-Preferred Providers, Non-Contracting Vision Providers or non-Contracting Pharmacy Providers.

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

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

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

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

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

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

C. Organ and Tissue Transplants. Transplants and related services must be coordinated and prior authorization must be obtained from CareFirst. Prior authorization is not required for cornea and kidney transplants. Coverage for related medications is available under Section 12, Prescription Drugs..

D. Ambulance Services. Prior authorization is required for air ambulance services only, except for Medically Necessary air ambulance services in an emergency.

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

1. Home Health Care Services, except Home Health Visits following a Mastectomy and surgical removal of a testicle post-partum Home Health Visits;
2. Skilled Nursing Facility Services;
3. Hospice Care Services;
4. Habilitative Services;
5. Controlled Clinical Trials;
6. General Anesthesia for Dental Care;
7. Inpatient Residential Treatment Center Facility Services.
8. Low Vision Services and Medically Necessary Contact Lenses; and,
9. Prescription Drugs on the Prescription Guidelines and human growth hormones.
10. Artificial insemination and intrauterine insemination.
11. In-vitro fertilization (IVF).

Covered Services not listed in Section 15.5 do not require prior authorization. CareFirst reserves the right to make changes to the categories of services that are subject to utilization management requirements or to the procedures the Member and/or the providers must follow. CareFirst will notify the Member of these changes at least forty-five (45) days in advance.

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

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

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

SECTION 16
EXCLUSIONS AND LIMITATIONS

The following exclusions apply:

16.1 Services or supplies that are determined by CareFirst 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 and 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.

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 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.

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.

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.

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.

16.49 Private duty nursing, unless authorized by CareFirst.

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, CareFirst shall pay as if only one Dentist rendered the service.

4. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to 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 CareFirst 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 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 Allowed Benefit is limited to that of a one-surface restoration. Any charges in excess of the 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 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 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 CareFirst.

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 CareFirst to be satisfactory or repairable.

6. Replacement of dentures or crowns within 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 CareFirst.

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. CareFirst 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 months of initial placement.

25. Rebase and/or reline denture within six months of initial placement and limited to one per 24 months after the six months following initial placement.

26. A preformed denture with teeth already mounted forming a denture module.

27. Crowns when received within 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 Vision Services. Benefits will not be provided for the following:

A. Any Covered Vision Service stated in Section 3 for Members over age 19, except for the vision examination. If the Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive covered pediatric vision services through the rest of that Calendar Year.

B. Diagnostic services, except as 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. Non-basic spectacle lenses, non-collection frames and non-collection contact lenses 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, Covered Vision 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 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.

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, Maryland 21117-5559

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

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT C
SCHEDULE OF BENEFITS - STUDENT HEALTH PLAN

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Agreement.

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

When determining the benefits a Member may receive, CareFirst 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.

GENERAL PROVISIONS	
DEDUCTIBLES	
IN-NETWORK DEDUCTIBLE	**OUT-OF-NETWORK DEDUCTIBLE**
The Individual Deductible is $250 per Benefit Period. The Family Deductible is $500 per Benefit Period.	The Individual Deductible is $500 per Benefit Period. The Family Deductible is $1,000 per Benefit Period.

IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES

Individual Coverage: The Member must satisfy the Individual Deductible.

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

The In-Network Deductible and the Out-of-Network Deductible are separate amounts and do not contribute to one another.

The following amounts may <u>not</u> be used to satisfy the In-Network OR Out-of-Network Deductibles:

- Amounts incurred for failure to comply with the utilization management program requirements.
- Difference between the price of a non-Preferred Brand Name Drug and Generic Drug when a Member selects a non-Preferred Brand Name Drug when a Generic Drug is available.
- Charges in excess of the Allowed Benefit.
- 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 Prescription Drugs.
- Charges for Pediatric Vision Services or Pediatric Dental Services.

The benefit chart below states whether a covered service is subject to a Deductible. If a Deductible applies, the chart will also state whether a Deductible applies to In-Network benefits, Out-of-Network benefits, or both.

OUT-OF-POCKET MAXIMUM	
IN-NETWORK OUT-OF-POCKET MAXIMUM	**OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM**
The Individual Out-of-Pocket Maximum is $5,000 per Benefit Period. The Family Out-of-Pocket Maximum is $10,000 per Benefit Period. **The following amounts apply to the In-Network Out-of-Pocket Maximum:** • Copayments for In-Network services. • Coinsurance for covered In-Network services, including In-Network Pediatric Dental Services. • The In-Network Deductible. • The In-Network Pediatric Dental Deductible. • Amounts paid toward Prescription Drugs. When the Member has reached the In-Network Out-of-Pocket Maximum, no further Copayments, Coinsurance, or Deductibles will be required in that Benefit Period for In-Network services.	The Individual Out-of-Pocket Maximum is $6,850 per Benefit Period. The Family Out-of-Pocket Maximum is $13,700 per Benefit Period. **The following amounts apply to the Out-of-Network Out-of-Pocket Maximum:** • Copayments and Coinsurance for covered Out-of-Network services, including Out-of-Network Pediatric Dental Services. Amounts paid for Prescription Drugs obtained from a non-Contracting Pharmacy Provider will be applied to the In-Network Out-of-Pocket Maximum. • The Out-of-Network Deductible. • The Out-of-Network Pediatric Dental Deductible. When the Member has reached the Out-of-Network Out-of-Pocket Maximum, no further Copayments, Coinsurance, or Deductibles will be required in that Benefit Period for Out-of-Network services.
IN-NETWORK AND OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM	
Individual Coverage: The Member must meet the Individual Out-of-Pocket Maximum. **Family Coverage:** Each Member can satisfy his/her own Individual Out-of-Pocket Maximum by meeting the Individual Out-of-Pocket Maximum. In addition, eligible expenses of all covered family members can be combined to satisfy the Family Out-of-Pocket Maximum. An individual family member cannot contribute more than the Individual Out-of-Pocket Maximum toward meeting the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum has been met, this will satisfy the Out-of-Pocket Maximum for all family members. The In-Network Out-of-Pocket Maximum and the Out-of-Network Out-of-Pocket Maximum are separate amounts and do not contribute to one another. **The following amounts may <u>not</u> be used to meet the In-Network or Out-of-Network Out-of-Pocket Maximum**: • Amounts incurred for failure to comply with the utilization management program requirements. • Difference between the price of a non-Preferred Brand Name Drug and Generic Drug when a Member selects a non-Preferred Brand Name Drug when a Generic Drug is available. • Charges in excess of the Allowed Benefit, 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. • Charges for Out-of-Network Covered Pediatric Vision Services.	

UTILIZATION MANAGEMENT
Failure or refusal to comply with utilization management program requirements will result in a 50% reduction in benefits for services associated with the Member's care or treatment (other than Medically Necessary inpatient Ancillary Services and Prescription Drug, Pediatric Vision and Pediatric Dental benefits).

BENEFITS				
	LIMITATIONS (Combined In-Network and Out-of-Network)		MEMBER PAYS	
SERVICE		SUBJECT TO DEDUCTIBLE?	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
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 for Clinic Visits/ Outpatient Services rendered in a hospital, hospital clinic, or health care provider's office on a hospital campus ("Clinic Visit"). These providers may bill individually resulting in claims from both the hospital/facility and the physician or health care provider rendering care in the hospital/facility/clinic setting. It is the Member's responsibility to determine whether separate claims will be assessed.				
OUTPATIENT FACILITY, OFFICE AND PROFESSIONAL SERVICES				
Physician's Office (Non-Preventive)	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.	In-Network and Out-of-Network	PCP: $25 per visit Specialist: $40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit 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		In-Network and Out-of-Network	PCP: $25 per visit Specialist: $40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
University Health Center		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Laboratory Tests, X-Ray/Radiology Services, Specialty Imaging and Diagnostic Procedures				
Non-Preventive Laboratory Tests (independent non-hospital laboratory)		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit

BENEFITS				
			MEMBER PAYS	
SERVICE	LIMITATIONS (Combined In-Network and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Non-Preventive Laboratory Tests (outpatient department of a hospital)		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Non-Preventive X-Ray/Radiology Services (independent non-hospital facility)		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Non-Preventive X-Ray/Radiology Services (outpatient department of a hospital)		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Non-Preventive Specialty Imaging (independent non-hospital facility)		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Non-Preventive Specialty Imaging (outpatient department of a hospital)		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Non-Preventive Diagnostic Testing except as otherwise specified (in an independent non-hospital facility)		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Non-Preventive Diagnostic Testing except as otherwise specified (in an outpatient department of a hospital)		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Sleep Studies (Member's home)		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Sleep Studies (office or freestanding facility)	Prior authorization is required.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Sleep Studies (outpatient department of a hospital)	Prior authorization is required.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
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		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Colorectal Cancer Screening		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Breast Cancer Screening		No	No Copayment or Coinsurance	No Copayment or Coinsurance

BENEFITS				
	LIMITATIONS (Combined In-Network and Out-of-Network)		MEMBER PAYS	
SERVICE		SUBJECT TO DEDUCTIBLE?	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Chlamydia Screening Test		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Human Papillomavirus Screening Test		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Laboratory Tests		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive X-Ray/Radiology Services		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Specialty Imaging		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Preventive Diagnostic Testing (except as otherwise specified)		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Immunizations		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Well Child Care (includes related lab tests and immunizations)		No	No Copayment or Coinsurance	No Copayment or Coinsurance
Adult Preventive Care		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Women's Preventive Services		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Osteoporosis Screening		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Office Visits for Treatment of Obesity		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Professional Nutritional Counseling and Medical Nutrition Therapy		Out-of-Network	No Copayment or Coinsurance	No Copayment or Coinsurance
Treatment Services				
Family Planning				
Non-Preventive Gynecological Office Visits		In-Network and Out-of-Network	$25 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Contraceptive Counseling		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit

BENEFITS				
	LIMITATIONS (Combined In-Network and Out-of-Network)		MEMBER PAYS	
SERVICE		SUBJECT TO DEDUCTIBLE?	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Contraceptive Drugs and Devices	Coverage of self-administered contraceptive drugs and devices is provided under the Prescription Drugs benefit.	Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
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.	Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Elective Sterilization Services - Female Members	Benefits available to female Members with reproductive capacity only.	Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
	Benefits are available to the same extent as benefits provided for other services			
Maternity and Related Services				
Preventive Visit		Out-of-Network	No Copayment or Coinsurance	20% of the Allowed Benefit
Non-Preventive Visit		In-Network and Out-of-Network	$25 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit 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		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Infertility Treatment				
Infertility Counseling and Testing		In-Network and Out-of-Network	$25 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic

BENEFITS				
	LIMITATIONS (Combined In-Network and Out-of-Network)		MEMBER PAYS	
SERVICE		SUBJECT TO DEDUCTIBLE?	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Artificial & Intrauterine Insemination	Prior authorization is required.	In-Network and Out-of-Network	$25 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit 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.	In-Network and Out-of-Network	$25 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit 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		In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Allergy Shots		In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit a**nd** 40% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic

BENEFITS				
	LIMITATIONS (Combined In-Network and Out-of-Network)		MEMBER PAYS	
SERVICE		SUBJECT TO DEDUCTIBLE?	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Rehabilitation Services				
Rehabilitative Physical Therapy	Limited to 30 visits (per injury or illness) per Benefit Period. This limitation does not apply to Habilitative services for Children or Adults.	In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40%of the Allowed Benefit 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 injury or illness) per Benefit Period. This limitation does not apply to Habilitative services for Children or Adults.	In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Rehabilitative Speech Therapy	Limited to 30 visits (per injury or illness) per Benefit Period. This limitation does not apply to services for cleft lip and cleft palate or Habilitative services for Children or Adults.	In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit 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.	In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit 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 under the age of 19. Prior authorization is required for Habilitative Services.	In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic

BENEFITS				
	LIMITATIONS (Combined In-Network and Out-of-Network)		MEMBER PAYS	
SERVICE		SUBJECT TO DEDUCTIBLE?	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Habilitative Services for Adults	Benefits available for Member age 19 and older. Limited to 30 visits (per injury or illness) per Benefit Period for Physical Therapy, 30 visits (per injury or illness) per Benefit Period for Occupational Therapy and 30 visits (per injury or illness) per Benefit Period for Speech Therapy. Prior authorization is required for Habilitative services for Adults.	In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Acupuncture		In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit 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.	In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit 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.	In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit 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 (Combined In-Network and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Other Treatment Services				
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation and pulmonary rehabilitation)		In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic
Infusion Services				
Physician's Office	Prior authorization is required for Specialty Drugs in the Prescription Guidelines.	In-Network and Out-of-Network	$20 per session	$70 per session
Free-Standing Infusion Center	Prior authorization is required for Specialty Drugs in the Prescription Guidelines.	In-Network and Out-of-Network	$20 per session	$70 per session
Hospital Outpatient Department	Prior authorization is required for Specialty Drugs in the Prescription Guidelines.	In-Network and Out-of-Network	$200 per session	$300 per session
Member's Home	Prior authorization is required for Specialty Drugs in the Prescription Guidelines.	In-Network and Out-of-Network	$20 per session	$70 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		In-Network and Out-of-Network	$25 per visit	20% of the Allowed Benefit
Telemedicine Services	Telemedicine does not include an audio-only telephone, electronic mail message, or facsimile transmission between a health care provider and a patient.	No	$25 per visit	20% of the Allowed Benefit
Outpatient Surgical Facility and Professional Services				
Surgical Care at an Ambulatory Care Facility		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit

BENEFITS				
	LIMITATIONS (Combined In-Network and Out-of-Network)		MEMBER PAYS	
SERVICE		SUBJECT TO DEDUCTIBLE?	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Outpatient Surgical Professional Services Provided at an Ambulatory Care Facility	Routine/Screening Colonoscopy is not subject to the In-Network Copayment and Deductible.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Surgical Care at an Outpatient Hospital Facility		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Surgical Professional Services Provided at an Outpatient Hospital	Routine/Screening Colonoscopy is not subject to the In-Network Copayment and Deductible.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
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.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Professional Services		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Organ and Tissue Transplants	Except for cornea 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.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
HOME HEALTH SERVICES				
Home Health Services	Prior authorization is required.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Postpartum Home Visits	Benefits are available to all Members.	No	No Copayment or Coinsurance	No Copayment or Coinsurance
Home Visits Following a Mastectomy and Surgical Removal of a Testicle		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
HOSPICE SERVICES				
Inpatient Care	Prior authorization is required.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Care	Prior authorization is required.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Respite Care	Prior authorization is required.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Bereavement Services	Prior authorization is required.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit

BENEFITS				
SERVICE	LIMITATIONS (Combined In-Network and Out-of-Network)	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED PROVIDER	NON-PREFERRED PROVIDER
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES				
Outpatient Services				
Office Visits		In-Network and Out-of-Network	$25 per visit	20% of the Allowed Benefit
Outpatient Hospital Facility Services		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Professional Services Provided at an Outpatient Hospital Facility		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Outpatient Psychological and Neuro-psychological Testing for Diagnostic Purposes		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Methadone Maintenance		No	20% of the Allowed Benefit	20% of the Allowed Benefit
Partial Hospitalization		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Professional Services at a Partial Hospitalization Facility		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Services				
Inpatient Facility Services	Prior authorization is required.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Professional Services		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Residential Treatment Center Services				
Inpatient Residential Treatment Center Facility Services	Prior authorization is required.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Inpatient Residential Treatment Center Professional Services		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
EMERGENCY SERVICES AND URGENT CARE				
Urgent Care Facility	Limited to unexpected, urgently required services.	In-Network and Out-of-Network benefit subject to In-Network Deductible	$50 per visit	$50 per visit
Hospital Emergency Room - Facility Services	Limited to Emergency Services or unexpected, urgently required services.	In-Network and Out-of-Network benefit subject to In-Network Deductible	$150 per visit, waived if admitted	$150 per visit, waived if admitted

BENEFITS				
	LIMITATIONS (Combined In-Network and Out-of-Network)		MEMBER PAYS	
SERVICE		SUBJECT TO DEDUCTIBLE?	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Hospital Emergency Room - Professional Services	Limited to Emergency Services or unexpected, urgently required services.	In-Network and Out-of-Network benefit subject to In-Network Deductible	20% of the Allowed Benefit	20% of the Allowed Benefit
Ambulance Service	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency.	In-Network and Out-of-Network benefit subject to In-Network Deductible	20% of the Allowed Benefit	20% of the Allowed Benefit
MEDICAL DEVICES AND SUPPLIES				
Durable Medical Equipment		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Orthotic and Prosthetic Devices		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Hair Prosthesis	Limited to one per Benefit Period.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Medical Food for Members with Metabolic Disorders		In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Breastfeeding Equipment and Supplies		Out-of-Network	No Copayment	20% of the Allowed Benefit
Diabetes Equipment	Coverage for Diabetes Supplies will be provided under the Prescription Drug benefit.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Hearing Aids				
Hearing Aids	Limited to one hearing aid for each hearing impaired ear every 36 months.	In-Network and Out-of-Network	20% of the Allowed Benefit	40% of the Allowed Benefit
Hearing Aid Related Services		In-Network and Out-of-Network	$40 per visit **and** 20% of the Allowed Benefit if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic	20% of the Allowed Benefit **and** 40% of the Allowed Benefit 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	Not covered

BENEFITS				
	LIMITATIONS (Combined In-Network and Out-of-Network)		MEMBER PAYS	
SERVICE		SUBJECT TO DEDUCTIBLE?	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Health Risk Assessment Feedback		No	No Copayment or Coinsurance	Not covered
PATIENT-CENTERED MEDICAL HOME				
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.	No	No Copayment or Coinsurance	Not covered

SERVICE	LIMITATIONS	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS	
			CONTRACTING PHARMACY PROVIDER	NON-CONTRACTING PHARMACY PROVIDER
PRESCRIPTION DRUGS				
• If a Generic Drug is not available, a Brand Name Drug shall be dispensed. • If a provider prescribes a non-Preferred Brand Name Drug, and the Member selects the non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the 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. • 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.				
Prescription Drugs	Limited to a 30-day supply per prescription or refill.	No	**Preventive Drugs, Diabetic Supplies and Oral Chemotherapy Drugs:** No Copayment or Coinsurance **Generic Drugs:** $10 per prescription or refill **Preferred Brand Name Drugs:** $45 per prescription or refill **Non-Preferred Brand Name Drugs:** $65 per prescription or refill	
Maintenance Drugs	Limited to a 90-day supply per prescription or refill. Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.	No	**Preventive Drugs, Diabetic Supplies and Oral Chemotherapy Drugs:** No Copayment or Coinsurance **Generic Drugs:** $20 per prescription or refill **Preferred Brand Name Drugs:** $90 per prescription or refill **Non-Preferred Brand Name Drugs:** $130 per prescription or refill	
Specialty Drugs	Benefits for Specialty Drugs are only available when 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 Specialty Drugs from a Pharmacy **outside** of the Exclusive Specialty Pharmacy Network.	No	**Specialty Drugs:** 50% of the Prescription Drug Allowed Benefit up to a Member maximum payment of $150 per prescription or refill for up to a 30-day supply of a non-Maintenance Drug 50% of the Prescription Drug Allowed Benefit up to a Member maximum payment of $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 through the rest of that Benefit Period.				
			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 through the rest of that Benefit Period.				
			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. 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.
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.

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 through the rest of that Benefit Period.	
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 above. Once the Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible or Coinsurance.	

			MEMBER PAYS	
SERVICE	LIMITATIONS	SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?	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

SERVICE	LIMITATIONS	SUBJECT TO PEDIATRIC DENTAL DEDUCTIBLE?	MEMBER PAYS	
			PREFERRED DENTIST	NON-PREFERRED DENTIST
Class V Orthodontic Services	Limited to Members with severe, dysfunctional, handicapping malocclusion. A pre-treatment estimate (PTE) must be submitted to CareFirst, and CareFirst 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 of Maryland, Inc.

Chester E. Burrell
President and Chief Executive Officer

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, Maryland 21117-5559

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

An independent licensee of the Blue Cross and Blue Shield Association

INTER-PLAN ARRANGEMENTS DISCLOSURE AMENDMENT

This amendment is effective on the effective date of the Agreement to which this amendment is attached. The Agreement is amended as follows:

Out-of-Area Services.

CareFirst has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members obtain healthcare services outside of the CareFirst service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

Typically, when accessing care outside the CareFirst service area, Members will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating/PPO 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 payment practices in both instances are described below.

A. BlueCard® Program.

Under the BlueCard® Program, when Members access covered healthcare services from a provider within the geographic area served by a Host Blue, CareFirst 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.

Whenever a Member accesses covered healthcare services outside the CareFirst service area and the claim is processed through the BlueCard Program, the amount the Member pays for covered healthcare services is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the 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.

While this provision applies when the cost-sharing is coinsurance, it would not apply if the cost-sharing is a flat dollar copayment.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted

above. However, such adjustments will not affect the price CareFirst uses for a claim because they will not be applied retroactively to claims already paid.

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 would then calculate Member liability for any covered healthcare services according to the laws of the State of Maryland.

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

B. Non-Participating Healthcare Providers Outside the CareFirst Service Area.

1. Member Liability Calculation.

   When covered healthcare services are provided outside of the CareFirst service area by non-participating healthcare providers, the amount(s) a 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 laws of the State of Maryland. In these situations, the Member may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. The Member will not be liable for this difference if the non-participating healthcare provider is a non-participating on-call physician who accepts an assignment of benefits.

2. Exceptions.

   In certain situations, CareFirst may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount CareFirst will pay for services rendered by non-participating healthcare providers. In these situations, the Member may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. The Member will not be liable for this difference if the non-participating healthcare provider is a non-participating on-call physician who accepts an assignment of benefits.

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 of Maryland, Inc.

Chester E. Burrell
President and Chief Executive Officer

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Inter-Plan PROGRAM ANCILLARY SERVICES Amendment

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

As used in this amendment, "Out-of-Area Covered Ancillary Services" mean:

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

Under the BlueCard® Program, Members are able to obtain Covered Ancillary Services outside the geographic area that CareFirst services. This program allows Members to obtain Out-of-Area Covered Ancillary Services from providers that have a contractual agreement (i.e., are "participating/PPO providers") with the local Blue Cross and/or Blue Shield Licensee in another geographic area, as well as non-participating providers.

As used in this amendment, the "Local Plan" means the plan that is responsible for processing Out-of-Area Covered Ancillary Services claims under the BlueCard® Program.

Member payment for Out-of-Area Covered Ancillary Services at the participating/PPO or non-participating provider payment level is determined by the relationship between the provider and the Local Plan. If the provider of Covered Ancillary Services has a contract with the Local Plan (a participating/PPO provider), the Member is responsible for the participating/PPO provider member payment as stated in the Inter-Plan Arrangements Disclosure Amendment.

If the provider of Covered Ancillary Services does not have a contract with the Local Plan (a non-participating provider), the Member is responsible for the non-participating provider member payment as stated in the Inter-Plan Arrangements Disclosure Amendment.

For Out-of-Area Covered Ancillary Services, the Local Plan is determined as follows:

Independent Clinical Laboratory Tests - if the referring provider is located in the same service area where the specimen was drawn, the plan of the service area where the specimen was drawn is the Local Plan; if the referring provider is not located in the same service area where the specimen was drawn, the plan of the service area where the referring provider is located is the Local Plan.

Medical Devices and Supplies - the plan of the service area where the equipment was shipped to or purchased at a retail store is the Local Plan.

Specialty Prescription Drugs - the plan of the service area where the ordering physician is located is the Local Plan.

This amendment is subject to all of the terms and conditions of the Evidence of Coverage to which it is attached and does not change any terms or conditions, except as specifically stated herein.

CareFirst of Maryland, Inc.

Chester E. Burrell
President and Chief Executive Officer

PATIENT PROTECTION DISCLOSURE NOTICE

Primary Care Provider Designation

CareFirst generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, CareFirst designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the CareFirst at the customer service telephone number listed on your identification card.

For children, you may designate a CareFirst pediatrician as the primary care provider.

Obstetrics and Gynecological Care

You do not need prior authorization from CareFirst or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of CareFirst health care professionals who specialize in obstetrics or gynecology, contact CareFirst at customer service telephone number listed on your identification card.

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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 of Maryland, Inc.
doing business as CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559
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

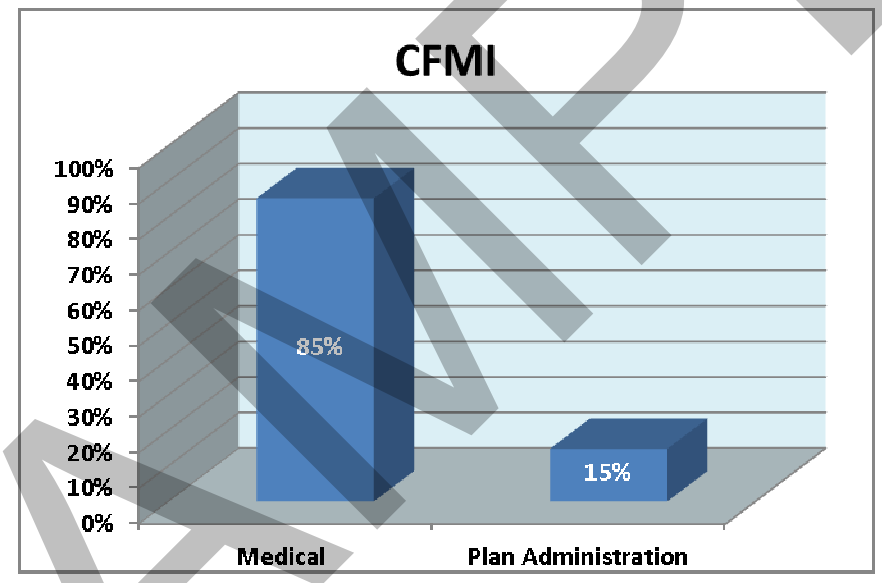
For its Indemnity and Preferred Provider Organization (PPO) products, CareFirst of Maryland, Inc. contracts directly with physicians. All physicians are reimbursed on a discounted fee-for-service basis.

C. DISTRIBUTION OF PREMIUM DOLLARS

The bar graph below illustrates the proportion of every $100 in premium used by CareFirst of Maryland, Inc. to pay providers for medical care expenses, and the proportion used to pay for plan administration.

These numbers represent an average for all indemnity accounts based on our annual statement. The ratio of direct medical care expenses to plan administration will vary by account.

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.



CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, Maryland 21117-5559

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

An independent licensee of the Blue Cross and Blue Shield Association.

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
  - $300,000 for disability insurance
  - $300,000 for long-term care insurance
  - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

NOTE: Certain policies and contracts many not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health
Insurance Guaranty Corporation
9199 Reisterstown Road
P.O Box 671-Suite 216C
Owings Mills, Maryland.21117
410-998-3907

Maryland Insurance
Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland.21202
1-800-492-6116, ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.