State of Maryland

SLEOLA

Preferred Provider Option with Vision Care Benefits

And

Preferred Provider Option with Medicare Option with Vision Care Benefits

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

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

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

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

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

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

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

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

Group Name: State of Maryland

Account Number: 56846

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DEFINITIONS

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

Air Ambulance Service means medical transport of Members by a rotary wing air ambulance, as defined in 42 C.F.R. 414.605, or fixed wing air ambulance, as defined in 42 C.F.R. 414.605.

All-Payer Model Agreement means an agreement between the Centers for Medicare & Medicaid Services (CMS) and a state to test and operate systems of all-payer payment reform for the medical care of residents of the particular state, under the authority granted under section 1115A the Social Security Act.

Allowed Benefit means:

1. For purposes of Preferred Provider Option with Medicare benefits:

    a. When services are covered by both Medicare and CareFirst, CareFirst's basis for the Allowed Benefit is the Medicare Part A/B deductible/coinsurance/copayment.

    b. When services are not covered by Medicare but are covered by CareFirst, CareFirst's basis for the Allowed Benefit is the same as the Allowed Benefit for Preferred Provider Option benefits.

2. For purposes of Preferred Provider Option benefits:

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

    b. **Non-Preferred Health Care Providers**:

        1) For Emergency Services, the Allowed Benefit for a Covered Service is the Recognized Amount. The benefit is payable to the Non-Preferred Health Care Provider. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits.

        2) For Non-Emergency Services performed by Non-Preferred Providers at Preferred Health Care facilities (including Ancillary Services and services for unforeseen urgent medical needs), the Allowed Benefit for a Covered Service is the Recognized Amount. The benefit is payable to the Non-Preferred Health Care Provider. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits

        3) For Non-Preferred Health Care Providers of Air Ambulance Services, the Allowed Benefit is the lesser of the provider's actual charge or the Qualifying Payment Amount. The benefit is payable to the Non-Preferred Health Care Provider. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits.

        4) For all other Covered Services provided by:

            a) A health care practitioner that is a Non-Preferred Health Care Provider, (except anesthesiologists and Ambulance Services Providers not including Air Ambulance Services), the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or

established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the Subscriber or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the health care practitioner. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the health care practitioner's actual charge.

b) For an anesthesiologist that is a Non-Preferred Health Care Provider, the Allowed Benefit for a Covered Service is based upon the practitioner's actual charge.

c) For an Ambulance Service Provider that is a Non-Preferred Health Care Provider and does not provide Air Ambulance Services, the Allowed Benefit for a Covered Service may not be less than the Allowed Benefit paid to an Ambulance Service Provider that has contracted with CareFirst 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 who accepts an Assignment of Benefits and is accepted as payment in full, except for any applicable Member payment amounts as stated in the Schedule of Benefits.

d) For a hospital or health care facility that is a Non-Preferred Health Care Provider, the Allowed Benefit for a Covered Service is based upon the lower of the provider's actual charge or established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Member payment amounts, as stated in the Schedule of Benefits. The benefit is payable to the Subscriber or to the hospital or health care facility, at the discretion of CareFirst. Benefit payments to United States Department of Defense and United States Department of Veteran Affairs providers will be made directly to the provider. If CareFirst pays the Subscriber, it is the Member's responsibility to pay the hospital or health care facility. Additionally, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge.

3. Outside of the Service Area, for a Health Care Provider that has contracted with a local Blue Cross and/or Blue Shield Licensee (not CareFirst BlueCross BlueShield), the Allowed Benefit is calculated as stated in the Inter-Plan Arrangements Disclosure section of this Evidence of Coverage.

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

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:

1. Is owned, operated, or under the jurisdiction of a political subdivision of a state, the District of Columbia, or a volunteer fire company or volunteer rescue squad; or

2. Has contracted to provide Ambulance services for a political subdivision of a state or the District of Columbia.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to:

1. Items and services furnished by a Non-Preferred Health Care Provider in a Preferred Health Care facility related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.

2. Items and services provided by health care practitioners.

3. Diagnostic services, including radiology and laboratory services.

4. Items and services provided by a Non-Preferred Health Care Provider if there is no Preferred Health Care Provider who can provide the services to the Member within the health care facility.

5. Other facility-based services like 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.

Assignment of Benefits means the transfer of health care coverage reimbursement benefits or other rights under the Evidence of Coverage 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.

Authorized Representative means an individual authorized by law to provide consent on behalf of the Member, provided that the individual is not a Health Care Provider affiliated with the health care facility or an employee of the health care facility, unless the Health Care Provider or employee is a family member of the Member.

Balance Bill or Balance Billing means the difference between the Non-Preferred Health Care Provider's actual charge for a Covered Service and the Allowed Benefit.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

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

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

Claims Administrator means CareFirst.

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

Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that has contracted with the local Blue Cross and/or Blue Shield Licensee (not CareFirst) and provides Ancillary Services to the Member outside of the CareFirst Service Area, as stated in the Inter-Plan Ancillary Services section.

Convenience Care means services provided at a Retail Health Clinic. Convenience Care are non-Emergency/non-Urgent Care services for the treatment of common ailments (e.g., ear, bladder, and sinus infections; pink eye; flu; and strep throat).

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose, including but not limited to: air conditioners, humidifiers, physical fitness equipment, elevators, hoyer/stair lifts, ramps, shower/bath bench, items available without a prescription).

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

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

Covered Service means a Medically Necessary service, services covered by this Evidence of Coverage as defined by the Group, or supply provided in accordance with the terms of this Evidence of Coverage.

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

Dependent means a Member other than the Subscriber, meeting the eligibility requirements established by the Group, who is covered under this Evidence of Coverage, as follows:

Spouse means an individual lawfully married to the Subscriber, as such marriage is recognized by the laws of the State of Maryland/or in a jurisdiction where such marriage is legal.

Dependent child means a biological child, adopted child, or step-child of the Subscriber (a) under the Limiting Age, or (b) over the Limiting Age but incapable of self-support due to mental or physical incapacity incurred or occurring prior to attaining the Limiting Age.

A biological, adopted, or step-child Dependent child is eligible for coverage regardless of:

1. Financial dependency on an individual covered under this Evidence of Coverage;
2. Marital status;
3. Residency with an individual covered under this Evidence of Coverage;
4. Student status;
5. Employment;
6. Eligibility for coverage under own employer health plan; or
7. Satisfaction of any combination of the above factors.

Dependent child also includes the Subscriber's grandchild, legal ward, step-grandchild, or other dependent child relatives under the Limiting Age. To be eligible for coverage as a Dependent child under this Evidence of Coverage, the Subscriber's grandchild, legal ward, step-grandchild, or other dependent child relatives must:

1. Be financially dependent solely on the Subscriber;

2. Be unmarried;

3. Reside with the Subscriber.

Domestic Partner means a person of the same and opposite sex who cohabitates/resides with the Subscriber in a Domestic Partnership.

Domestic Partnership means a relationship between a Subscriber and Domestic Partner that satisfies the Group's Domestic Partner requirements.

Note: Except for the "Special Enrollment Periods" of the Eligibility and Enrollment section and Infertility Services, references in this Evidence of Coverage to a Dependent spouse shall be construed to include a Domestic Partner. References in this Evidence of Coverage to Dependent child shall be construed to include a child of a Domestic Partner.

Diabetes Supplies means Medical Supplies prescribed by a Health Care Provider for the treatment of diabetes.

Diagnostic Breast Examinations means medically necessary and appropriate examination of the breast that is used to evaluate an abnormality that is seen or suspected from a prior screening examination for breast cancer or detected by another means of prior examination. Diagnostic Breast Examinations includes an examination using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound.

EBD means the Group's Employee Benefits Division.

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

Emergency Facility means:

1. An emergency department of a hospital;

2. An Independent Freestanding Emergency Department; or

3. For purposes of covered post-stabilization Emergency Services, as described in this Evidence of Coverage, provided by Non-Preferred Health Care Providers, a hospital (regardless of the department of the hospital where the post-stabilization services are provided to the Member).

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

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

3. Serious dysfunction of any bodily organ or part.

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

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a hospital, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition;

2. Any such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the Member, regardless of the department of the hospital in which such further examination or treatment is furnished to the Member. The term "to stabilize" with respect to an Emergency Medical Condition, means to provide such medical treatment of the Emergency Medical Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the Member from a facility; and

3. Post-stabilization services (i.e., services provided after the Member has been stabilized, as part of outpatient observation, or an inpatient or outpatient stay related to the Emergency Services provided, as described above) as described in the Description of Covered Services of this Evidence of Coverage.

Employee Benefits Division means EBD.

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

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

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

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

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

3. The Technology must improve the net health outcome;

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

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

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

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

Fertility Awareness–Based Methods means methods of identifying times of fertility and infertility by an individual to avoid pregnancy including:

1. Cervical mucus methods;

2. Symptom-thermal or symptom-hormonal methods;

3. The standard days method; and,

4. The lactational amenorrhea method.

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

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

Habilitative Services means health care services and devices, including, but not limited to, Occupational Therapy, Physical Therapy, and Speech Therapy that help a child keep, learn, or improve skills and functioning for daily living.

Health Care Provider means a hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide Covered Services; and an individual who is registered as a Christian Science practitioner in the Christian Science Journal of the Christian Science Publishing Society.

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

1. The Member is under the care of a Health Care Provider;

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

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

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

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

2. 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.

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

Independent Freestanding Emergency Facility means a health care facility that is geographically separate and distinct, and licensed separately from a hospital under applicable law, and which provides Emergency Services.

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

Lifetime Maximum means the maximum dollar amount payable toward a Member's claims for Covered Services while the Member is covered under this Group Contract. Essential Health Benefits Covered

Services are not subject to the Lifetime Maximum. See the Schedule of Benefits to determine if there is a Lifetime Maximum for Covered Services that are **not** Essential Health Benefits.

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

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

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

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

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

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

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

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

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

Non-Contracted Health Care Provider means, for purposes of the Inter-Plan Ancillary Services section of this Evidence of Coverage, a Health Care Provider that does not contract with the local Blue Cross and/or Blue Shield Licensee (not CareFirst) and provides Ancillary Services to the Member outside of the CareFirst Service Area, as stated in the Inter-Plan Ancillary Services section.

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

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

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

1. Has privileges at a hospital;

2. 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

3. Is not a Hospital-Based Physician.

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

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

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

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

Partial Hospitalization means the provision of medically directed intensive or intermediate short-term treatment in a licensed or certified facility or program for treatment of mental illnesses, emotional or behavioral disorders, or substance use disorders.

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

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

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

Preferred Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members. The "Preferred" terminology relates only to method of payment and is not an indication that any Health Care Provider is more or less qualified than another.

Prescription Drug means:

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

2. 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.

Prescription Drug means:

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

2. 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.

3. Over-the-Counter medication or supply, if Over-the-Counter medications or supply are Covered Services under this Evidence of Coverage.

4. Diabetes Supplies.

5. Prescription Drugs do not include:

   a. Compounded bulk powders that contain ingredients that:

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

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

      3) Do not require a prescription to be dispensed.

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

      1) There is no commercially available bio-equivalent Prescription Drug; or
      2) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

Primary Care Physician (PCP) means a Preferred Provider, who is a health care practitioner in the following disciplines:

1. Family practice;

2. General practice;

3. Geriatrics;

4. Gynecology;

5. Internal Medicine;

6. Obstetrics/Gynecology;

7. Pediatrics;

8. Nurse Practitioner.

Private Duty Nursing means Skilled Nursing Care services, ordered by a Health Care Provider, that can only be provided by a licensed health care professional, based on a Plan of Treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.

Qualifying Payment Amount means an amount calculated based on the median contracted rate for all plans offered by CareFirst in the self-funded group medical benefits plan market for the same or similar item or service that is:

1. Provided by a Health Care Provider in the same or similar specialty or facility of the same or similar facility type; and

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

Recognized Amount means an amount determined as follows:

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

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

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

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

   b. The Qualifying Payment Amount.

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

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

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

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

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

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

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

3. Provided by entities that are licensed by the applicable licensing laws of any state or the District of Columbia to provide Residential Crisis Services; or

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

Retail Health Clinic means mini-medical office chains typically staffed by nurse practitioners with an on-call physician and which provides Convenience Care services.

Retroactive Effective Date means the Subscriber's date of qualifying event as determined by the EBD. A Subscriber may request a Retroactive Effective Date if Emergency Services are required prior to the Effective Date. If the EBD approves a Retroactive Effective Date, the Subscriber will be required to pay their share of the Premiums back to the date of the qualifying event.

Serious or Complex Condition means:

1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

2. In the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and

3. Requires specialized medical care over a prolonged period of time.

Service Area means CareFirst's Service Area, a 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.

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

1. Inpatient hospital/facility or Skilled Nursing Facility:

    a. Skilled Nursing Care rendered on an inpatient basis, means care for medically fragile Members with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the Member's safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week.

2. Skilled Nursing Care provided in the home:

    a. Medically Necessary skilled care services performed by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).

    b. Skilled Nursing Care home visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if the visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).

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

    d. Skilled Nursing Care services in a Home Health Care setting must be based on a Plan of Treatment submitted by a Health Care Provider.

3. Outpatient Private Duty Nursing:

    a. Medically Necessary skilled care services performed by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN).

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

    c. Skilled Nursing Care must be ordered by a Health Care Provider and based on a Plan of Treatment that specifically defines the skilled services to be provided as well as the time and duration of the proposed services.

Skilled Nursing Care is not Medically Necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the Activities of Daily Living (ADL), including, but not limited to, bathing, feeding, and toileting is not Skilled Nursing Care.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that provides continuous Skilled Nursing Care or Rehabilitative Services.

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

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

Specialty Drug means Prescription Drugs which include, but are not limited to, drugs that are high cost, large molecule, with high potential for adverse effects, have stability concerns requiring special handling, and/or are often derived from biologic processes rather than chemical processes. These drugs are often highly effective when used according to a strict administration regimen and therefore may require support and management services.

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

Spouse means a person of the same or opposite sex who is legally married to the Subscriber under the laws of the state or jurisdiction in which the marriage took place. A marriage legally entered into in another jurisdiction will be recognized as a marriage in the State of Maryland.

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

Supplemental Breast Examinations means medically necessary examination of the breast that is used to screen for breast cancer when there is no abnormality seen or suspected from a prior examination and there is a personal or family medical history or additional factors that may increase the Member's risk of breast cancer. Supplemental breast examination includes an examination using breast magnetic resonance.

Telemedicine Services means the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the Member at a site other than the site where the Member is located.

Treating Health Care Provider means a physician or other Health Care Provider who has evaluated the Member.

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Evidence of Coverage are Individual, Individual and Child, Individual and Spouse, and Family.

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 a hospital emergency room or department.

For purposes of Emergency Services, an Urgent Care facility is considered an Independent Freestanding Emergency Department (i.e., an Emergency Facility), if the Urgent Care facility:

1. Is located in a state where health care facility licensure laws allow Urgent Care facilities to provide Emergency Services;

2. Is geographically separate and distinct from a hospital; and

3. Is licensed separately from a hospital.

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

ELIGIBILITY AND ENROLLMENT

A. **Requirements for Coverage**

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

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

1. The individual elects coverage;

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

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

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

B. **Enrollment Opportunities and Effective Dates**

Eligible individuals may elect coverage as Subscribers or Dependents, as applicable, only during the following times and under the following conditions. If an individual meets these conditions, his or her enrollment will be treated as timely enrollment. Enrollment at other times will be treated as special enrollment and will be subject to the conditions and limitations stated in Special Enrollment Periods. Disenrollment is not allowed during a contract year except as stated in section B.1., and as stated in the Termination of Coverage section of the Evidence of Coverage.

1. **Open Enrollment Period**

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

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

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

2. **Newly Eligible Subscriber**

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

3. **Special Enrollment Periods**

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

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

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

If retirees are eligible for coverage under this Evidence of Coverage, references to an employee shall be construed to include a retiree, except for references made in the context of special enrollment for certain individuals who lose coverage, as special enrollment for certain individuals who lose coverage is not applicable to retirees.

a. Special enrollment for certain individuals who lose coverage:

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

2) Individuals eligible for special enrollment.

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

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

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

(3) The employee satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.

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

(1) The dependent and the employee are otherwise eligible to enroll;

(2) When coverage was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(3) The dependent satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.

(4) However, CareFirst is not required to enroll any other dependent unless the dependent satisfies the criteria of this paragraph B.3.a.2)b), or the employee satisfies the criteria of paragraph B.3.a.2)a) of this section.

3) Conditions for special enrollment.

a) Loss of eligibility for coverage. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph B.3.a.3)a) are satisfied

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

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

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

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

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

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

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

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

4) Applying for special enrollment and effective date of coverage. The Group or CareFirst will allow an employee a period of sixty (60) days after an event described above to request enrollment (for the employee or the employee's dependent).

a) Coverage will begin no later than the first day of the first (1st) calendar month beginning after the date the Group or CareFirst receives the request for special enrollment.

b. Special enrollment with respect to certain dependent beneficiaries:

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

2) Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph B.3.a.2)a), b), c), d), e), or f) of this section.

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

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

(1) The individual becomes the Spouse of a participant; or

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

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

(1) The employee and the Spouse become married; or

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

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

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

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

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

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

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

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

MEDICAL CHILD SUPPORT ORDERS

A. **Definitions**

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

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

   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.

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

B. **Eligibility and Termination**

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

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

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.

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

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

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

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

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

1) The employer has eliminated family member's coverage for all employees; or

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

C. **Administration**

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

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

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

3. Provide benefits directly to:

a. The non-insuring parent;

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

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

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TERMINATION OF COVERAGE

A. **Disenrollment of Individual Members**

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

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

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

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

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

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

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

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

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

7. The Subscriber is responsible for notifying CareFirst (through the Group) of any changes in the status of Dependents that affect their eligibility for coverage. If the Subscriber does not notify CareFirst of these types of changes and it is later determined that a Dependent was not eligible for coverage, CareFirst has the right to recover these amounts from the Subscriber or from the Dependent, at CareFirst's option.

B. **Death of a Subscriber**

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

C. **Effect of Termination**

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

D. **Reinstatement**
Coverage will not reinstate automatically under any circumstances.

CONTINUATION OF COVERAGE

A. **Continuation of Eligibility upon Loss of Group Coverage**

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

Additionally, if the Group health benefit Plan provided under this Evidence of Coverage is subject to COBRA, continuation of participation in this Group health plan must be made available to a Spouse following a divorce, if the Spouse's coverage was terminated by the Subscriber in anticipation of a divorce (or legal separation, if legal separation would trigger a loss of coverage under the terms of the plan) and as a result of the termination of coverage based on the anticipated Qualifying Event, the Spouse was no longer enrolled in the plan at the time the divorce became effective.

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

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

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

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

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

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

2. **Definitions**
For the purpose of this Extension of Benefits for Inpatient or Totally Disabled Individuals section, the following terms are defined. The definitions of other capitalized terms are found in the definitions sections throughout this Evidence of Coverage.

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

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

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

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

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

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

   If the Member is Totally Disabled upon his/her discharge from the hospital, the extension of benefits described in paragraph 1., above applies; however, an additional twelve (12) month extension of benefits is not provided. An individual is entitled to only one (1), twelve (12) month extension, not an inpatient twelve (12) month extension and an additional Totally Disabled twelve (12) month extension.

4. This section does not apply if:

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

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

COORDINATION OF BENEFITS; SUBROGATION

A. **Coordination of Benefits**

1. **Applicability**

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

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

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

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

2. **Definitions**

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

CareFirst Plan means this Evidence of Coverage.

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

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

The term Plan does not include:

a. An individually underwritten and issued, guaranteed renewable, specified disease policy, or specified accident policy;

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

c. Coverage regulated by a motor vehicle reparation law;

d. Any hospital indemnity or other fixed indemnity coverage contract;

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

f. Medicare supplemental policies;

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

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

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

j. A state plan under Medicaid; or

k. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

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

a. 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.

b. 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.

c. 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.

3. **Order of Benefit Determination Rules**

a. **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:

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

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

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

1) 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:

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

b) 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.

2) 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:

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

(1) 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

(2) 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.

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

(1) 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 3.b.2)a) 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.

(2) 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:

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

(b) The Plan of the spouse of the parent with the custody of the child;

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

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

c) 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 a) and b) of this paragraph as if those individuals were parents of the child.

3) 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.

4) 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:

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

b) 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.

5) 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.

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

a. **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.

b. **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 Allowed Benefit. 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.

5. **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.

6. **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.

7. **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:

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

   b. Insurance companies; or

   c. Other organizations.

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

B. **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:

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

2. 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.

C. **Subrogation**

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

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

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

   c. Covered by No Fault Insurance. No Fault Insurance means motor vehicle

casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose. CareFirst will not subrogate a recovery made under Personal Injury Protection policy benefits.

2. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Evidence of Coverage, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst provided or will provide benefits. CareFirst may recover the amounts paid in benefits up to the amount received from or on behalf of the third party. CareFirst will not recover from payments made to the Member under the Member's personal injury protection benefits of their motor vehicle insurance 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.

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

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

   For purposes of this provision, "made whole" means that the Member fully recovers all of their damages.

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

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

HOW THE PLAN WORKS

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

A. **Appropriate Care and Medical Necessity**

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

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

B. **Choosing a Provider:** Preferred Provider; Preferred Provider with Medicare

1. Member/Health Care Provider Relationship

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

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

2. Preferred Health Care Providers

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

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

   b. Claims will be submitted directly to CareFirst by the Preferred Health Care Provider.

   c. CareFirst will pay benefits directly to the Preferred Health Care Provider and such payment is accepted as payment in full, except for applicable Member amounts.

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

3. Medicare Participating Providers

Physicians and medical suppliers across the nation may sign an agreement with Medicare to become Medicare participating providers. Medicare participating providers agree to accept the Medicare approved amount as the total charge for services and supplies covered under Part B, commonly referred to as "accepting assignment." Other Providers may not have signed an agreement with Medicare but may accept assignment on certain services and supplies.

When an in-network Provider does not accept Medicare assignment, CareFirst will pay up to the Medicare limiting charge (15% of Medicare's approved amount).

When an out-of-network Provider does not accept Medicare assignment, the Member may be asked to pay the Health Care Provider at the time care is received. After the Deductible, Coinsurance or Copayment, CareFirst will pay up to the Medicare limiting charge. The Medicare limiting charge does not always apply.

It is to the Member's advantage to talk to his or her Health Care Provider and find out on what services and supplies the Health Care Provider will accept assignment.

4. Non-Preferred Health Care Providers

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

a. For Emergency Services provided by a Non-Preferred Health Care Provider:

1) All benefits for Covered Services will be payable directly to the Non-Preferred Health Care Provider.

2) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Non-Preferred Health Care Provider.

3) The Member is not responsible for the difference between CareFirst's payment and the Non-Preferred Health Care Provider's charge.

4) Benefits for Emergency Services by Non-Preferred Health Care Providers are available to the same extent as benefits available for Emergency Services provided by Preferred Health Care Providers. See the Schedule of Benefits for details.

b. For Covered Services provided by a Non-Preferred Health Care Provider in a Preferred Health Care facility (including Ancillary Services and Services for unforeseen urgent medical needs):

1) Except when the Non-Preferred Health Care Provider satisfies the Notice and Consent Requirements (described below):

a) All benefits for Covered Services will be payable directly to the Non-Preferred Health Care Provider.

b) In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a QMSO, payment will be

paid directly to the State of Maryland Department of Health or the non-insuring parent if proof is provided that such parent has paid the Non-Preferred Health Care Provider.

c) The Member is not responsible for the difference between CareFirst's payment and the Non-Preferred Health Care Provider's charge.

d) Benefits for Covered Services provided by a Non-Preferred Health Care Provider in a Preferred Health Care facility (including Ancillary Services and Services for unforeseen urgent medical needs) are available to the same extent as benefits available for Covered Services provided by Preferred Health Care Providers. See the Schedule of Benefits for details.

2) Notice and Consent Requirements

a) The Non-Preferred Health Care Provider satisfies the notice and consent criteria of 45 C.F.R. §149.420, by:

(1) Providing to the Member notice that the Health Care Provider is a Non-Preferred Health Care Provider, and an estimate of the charges for the Covered Services; and

(2) Obtaining consent from the Member (or the Member's Authorized Representative) to be treated and Balance Billed by the Non-Preferred Health Care Provider.

b) When the Non-Preferred Health Care Provider satisfies the notice and consent requirements, Covered Services are subject to the provisions of section B.3.c., below.

c) Notice and consent requirements described above, do not apply to:

(1) Ancillary Services; and

(2) Covered Services provided as a result of unforeseen, urgent medical needs, that arise at the time other Covered Services are being rendered, regardless of whether the Non-Preferred Health Care Provider satisfied the notice and consent requirements.

These Covered Services are always subject to the provisions of section B.3.b.1), above.

c. For all other Covered Services provided by a Non-Preferred Health Care Provider (except as otherwise authorized by CareFirst or stated in this Evidence of Coverage):

1) If a Member chooses a Non-Preferred Health Care Provider, Covered Services may be eligible for reduced benefits.

2) All benefits for Covered Services will be payable to the Subscriber, to the Non-Preferred Health Care Provider, or an Ambulance Service Provider who accepts an Assignment of Benefits, at the discretion of CareFirst.

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

4) Non-Preferred Health Care Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Member up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Member. Therefore, when Covered Services are provided by Non-Preferred Health Care Providers, Members should expect to pay additional amounts to providers that exceed the Allowed Benefit. Except for Covered Services rendered by an Ambulance Service Provider who accepts an Assignment of Benefits, the Member is responsible for the difference between CareFirst's payment and the Non-Preferred Health Care Provider's charge.

5. Ambulance Services Providers

a. For purposes of calculating the Member payment for ambulance Covered Services, refer to the quick reference guide below.

Quick Reference Guide		
Type of ambulance Covered Service:	**Preferred Health Care Provider**	**Non-Preferred Health Care Provider**
Air Ambulance Services	**Non-Emergency and Emergency ambulance services:** No Balance Billing is permitted.	**Non-Emergency and Emergency ambulance services:** No Balance Billing is permitted.
Other ambulance Covered Services	**Non-Emergency and Emergency ambulance services:** No Balance Billing is permitted.	**Non-Emergency ambulance services:** Balance Billing is permitted. **Emergency ambulance services:** No Balance Billing is permitted.

b. For Air Ambulance Services provided by a Non-Preferred Ambulance Services Provider, the Allowed Benefit is as stated in this Evidence of Coverage.

c. For other Ambulance Services provided by a Non-Preferred Ambulance Services Provider, the Allowed Benefit for a Covered Service may not be less than the Allowed Benefit paid to an Ambulance Service Provider that has contracted with CareFirst for the same Covered Service in the same geographic region, as defined by the Centers for Medicare and Medicaid Services.

d. The benefit is payable to the Ambulance Service Provider who accepts an Assignment of Benefits and is accepted as payment in full, except for any applicable Member payment amounts as stated in the Schedule of Benefits.

e. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts stated in the Schedule of Benefits.

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

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

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

1. Claims for medical benefits must be submitted within twelve (12) months following the dates services were rendered.

2. Claims for Vision Care Benefits must be submitted within twelve (12) months following the dates services were rendered.

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

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

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

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

H. **Assignment of Benefits**
A Member cannot assign any benefits or payments due under this Evidence of Coverage to any person, corporation or other organization, except a Member may:

1. Make an Assignment of Benefits to a Non-Preferred Provider who is a physician, a Hospital-Based Physician, an On-Call Physician; or an Ambulance Service Provider or

2. Assign any other benefits or payments under the Evidence of Coverage only as specifically provided by this Evidence of Coverage or required by law.

3. Notwithstanding any permitted and valid Assignment of Benefits, CareFirst may refuse to directly reimburse a Non-Preferred Provider who is a physician, a Hospital-Based Physician or an On-Call Physician if:

a. CareFirst receives notice of the Assignment of Benefits after the time that it has paid the benefits to the Member;

b. CareFirst, due to an inadvertent administrative error, has previously paid the Member;

c. The Member withdraws the Assignment of Benefits before CareFirst has paid the Non-Preferred Provider who is a physician, a Hospital-Based Physician or an On-Call Physician; or

d. The Member paid the Non-Preferred Provider who is a physician, a Hospital-Based Physician or an On-Call Physician the full amount due at the time of service.

I. **Evidence of Coverage**

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

J. **Notices**

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 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. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst of an address change.

K. **Privacy Statement**

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

REFERRALS

Referral Requirements

A. Referrals are not required, except as stated in the Gender Dysphoria Services subsection of the Description of Covered Services.

B. Referral to a Specialist or Non-Physician Specialist

1. Non-Physician Specialist means a Heath Care Provider who is not a physician who is licensed or certified under the Health Occupations Article of the Annotated Code of Maryland/or the applicable licensing laws of any state or the District of Columbia; and is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.

2. A Member may request a referral to a Specialist or Non-Physician Specialist who is a Non-Preferred Health Care 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 contracted 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.

3. For purposes of calculating any Member payment, CareFirst will treat the services provided by the specialist or Non-Physician Specialist as if the services were provided by a Preferred Health Care Provider.

C. Referrals Quick Reference

While referrals are not required, except as stated in the Gender Dysphoria Services subsection of the Description of Covered Services, Covered Services will be available as follows:

For Covered Services under this Evidence of Coverage:		
Type of Covered Service	**If a Member sees a:**	
	Preferred Health Care Provider	**Non-Preferred Health Care Provider**
Emergency Services	Benefits are available at the in-network level of benefits. No Balance Billing is permitted.	Benefits are available at the in-network level of benefits. No Balance Billing is permitted.
With a referral or without a referral: Covered Services provided by a Non-Preferred Health Care Provider in a Preferred Health Care facility	Not applicable	**With Member Notice and Consent:** (See the *"How the Plan Works"* section) Benefits are available to the same extent as "Other Covered Services" provided by Non-Preferred Health Care Providers, as stated below. **Without Member Notice and Consent:** (See the *"How the Plan Works"* section) Benefits are available at the In-Network level of benefits. No Balance Billing is permitted.
Other Covered Services	**With a referral or without a referral:** Benefits are available at the In-Network level of benefits. No Balance Billing is permitted.	**With a referral:** Benefits are available at the In-Network level of benefits. Balance Billing is permitted. **Without a referral:** Covered Services will be paid at the out-of-network level of benefits if out-of-network benefits are provided; otherwise, no benefits will be provided. Balance Billing is permitted.

This Referrals Quick Reference guide is subject to the terms stated in the Referral to a Specialist or Non-Physician Specialist section, above.

UTILIZATION MANAGEMENT REQUIREMENTS

Failure to meet the requirements of the utilization management or to obtain prior authorization for services may result in a reduction or denial of the Member's benefits even if the services are Medically Necessary.

Most Prescription Drugs classified as Specialty Drugs require prior authorization; prior authorization applies to Specialty Drugs covered under the medical portion of this Evidence of Coverage (i.e., Specialty Drugs administered in outpatient facilities, home, or office settings) and for Specialty Drugs covered under the Prescription Drug Benefits Rider (i.e., pharmacy-dispensed). Specialty Drugs are defined in the Definitions section of this Evidence of Coverage. Preferred Health Care Providers located in the Service Area will obtain prior authorization from CareFirst on behalf of the Member. Covered Ancillary Services that use Specialty Drugs which require prior authorization do not require an additional prior authorization/a Plan of Treatment. Failure to obtain prior authorization may result in denial of the claim.

A. Plan of Treatment

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

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

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

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

4. Within the Service Area, a Preferred Health Care Provider will complete and submit a Plan of Treatment. Outside the Service Area, the Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by a Health Care Provider, regardless of whether the provider is a Preferred Health Care Provider or a Non-Preferred Health Care Provider.

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

   a. Applied Behavioral Analysis (ABA)

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

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

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

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

   b. Cardiac Rehabilitation

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

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

c. Habilitative Services

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

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

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

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

d. Home Health Care

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

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

e. Hospice Care

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

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

f. Infertility Services: Artificial Insemination

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

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

g. Infertility Services: In-Vitro Fertilization

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

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

h. Private Duty Nursing

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

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

That is, benefits for outpatient Private Duty Nursing benefits will be denied if no plan of treatment is obtained. As stated above, the Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by the Health Care Provider. If the Plan of Treatment is not submitted or is submitted late (at any point after commencing outpatient Private Duty Nursing Care) the Member will be penalized by a 20% reduction on the outpatient Private Duty Nursing benefit otherwise available.

i. Rehabilitative Services: Occupational Therapy; Physical Therapy
CareFirst must approve the Plan of Treatment after the 20th visit. Visit limitation is per Benefit Period, per Member while covered by CareFirst.

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

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

The requirements of this subsection g., do not apply to Occupational Therapy or Physical Therapy visit when the services provided on the same day as a surgical Covered Service.

j. Rehabilitative Services: Speech Therapy

CareFirst must approve the Plan of Treatment after the 1st visit. Visit limitation is per Benefit Period, per Member while covered by CareFirst.

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

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

k. Spinal manipulation/Chiropractic services; Acupuncture
For chronic pain management, CareFirst must approve the Plan of Treatment after the 1st visit.

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

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

B. Hospital Pre-Certification and Review

A Preferred Health Care Provider, in and out of the Service Area, will obtain Hospital Pre-Certification and Review. The Member is responsible for ensuring a Non-Preferred Health Care Provider obtains Hospital Pre-Certification and Review, both in and out of the Service Area.

1. Hospital Pre-Certification and Review Process

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

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

c. Procedures which are normally performed on an outpatient basis will not be approved to be performed on an inpatient basis, unless unusual medical conditions are found through Hospital Pre-Certification and Review.

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

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

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

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

h. Hospital Pre-Certification and Review is not applicable to maternity admissions, and admissions for cornea and kidney transplants.

2. Non-Emergency (Elective) Admissions

a. The Member must provide any written information requested by the reviewer for Hospital Pre-Certification and Review of the admission at least twenty-four (24) hours prior to the admission.

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

c. For Out-of-Network Covered Services:

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

2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the elective admission was Medically Necessary:

a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 20%;

b) The Member is responsible for this penalty.

3. Emergency (Non-Elective) Admissions

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

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

1) The Member's insurance status; and

2) The reviewer's emergency admission notification requirements.

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

1) During the first twenty-four (24) hours the Member is in an inpatient facility; or

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

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

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

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

1) A Member will have to pay:

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

b) Non-Preferred Health Care Providers if a non-elective admission results in payment denial.

2) Neither the Member nor the Group will have to pay Preferred Providers:

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

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

d. For Out-of-Network Covered Services:

1) CareFirst will not provide benefits for a non-elective admission which is not Medically Necessary. The Member is responsible for the entire admission.

2) If a Member does not follow the Hospital Pre-Certification and Review guidelines and the reviewer determines that the non-elective admission was Medically Necessary:

a) CareFirst will reduce benefits for room, board; and hospital ancillary charges by 20%; and

b) The Member is responsible for this penalty.

Benefits will be provided subject to the terms of section B.3.a., above.

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

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

6. Program Monitoring

a. The Member's medical record will be reviewed by the reviewer.

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

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

1) Verify that the services are covered under the Evidence of Coverage; and

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

7. Notice and Appeals

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

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

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

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

C. Second Surgical Opinion

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

D. Case Management

This is a feature of this health benefit plan for a Member with a chronic condition, a serious illness, or complex health care needs. CareFirst will initiate and perform Case Management services, as deemed appropriate by CareFirst, which may include the following:

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

2. Education of individual/family regarding disease, treatment compliance and self-care techniques.

3. Help with organization of care, including arranging for needed services and supplies.

4. Assistance in arranging for a principal or primary care physician to deliver and coordinate the Member's care, and/or consultation with physician specialists; and

5. Referral of Member to community resources.

INTER-PLAN ARRANGEMENTS DISCLOSURE

Out-of-Area Services

Overview

CareFirst BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan. The Inter-Plan Programs are described generally below.

When a Member receives care outside of CareFirst's service area, it will be received from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. CareFirst explains below how CareFirst pays both kinds of providers.

Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst's service area, e.g., Emergency Services. If applicable, any difference between benefits for care received in CareFirst's service area and care received outside the geographic area CareFirst serves is stated in the Definitions.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by CareFirst to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when a Member receives Covered Services within the geographic area served by a Host Blue, CareFirst will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When a Member receives Covered Services outside CareFirst's service area and the claim is processed through the BlueCard Program, the amount a Member pays for Covered Services is calculated based on the lower of:

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

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price CareFirst has used for a claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, CareFirst may process claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount a Member pays for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to CareFirst by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to a Member, the Member will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, a Member will incur no liability, other than any related Member cost sharing.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, CareFirst will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside CareFirst's Service Area

1. Member Liability Calculation

When Covered Services are provided outside of CareFirst's service area by nonparticipating providers, the amount a Member pays for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, a Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, CareFirst may use other payment methods, such as billed charges for Covered Services, the payment CareFirst would make if the healthcare services had been obtained within CareFirst's service area, or a special negotiated payment to determine the amount CareFirst will pay for services provided by nonparticipating providers. In these situations, the Member may be liable for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core® Program

If a Member is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), the Member may be able to take advantage of the Global Core Program when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If a Member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if a Member contacts the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for cost-share amounts. In such cases, the hospital will submit Member claims to the service center to begin claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Services. **Members must contact CareFirst to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When Members pay for Covered Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from CareFirst, the service center or online at www.bcbsglobalcore.com. If Members need assistance with their claim submission, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

INTER-PLAN PROGRAMS ANCILLARY SERVICES

A. **Definitions**

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

1. Independent clinical laboratory tests (performed at non-hospital based labs);

2. Medical Devices and Supplies; and

3. Specialty Prescription Drugs (including non-routine, biological therapeutics such as injectables, infusion therapies, high-cost therapies, and therapies that require complex care).

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

B. **Member Payment**

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

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

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

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

C. **Determining the Local Plan**

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

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

BENEFITS FOR MEMBERS ENTITLED TO MEDICARE
(Medicare Complementary)

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

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

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

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

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

For Medicare as Primary Members, the in-network level of benefits will be determined following the Medicare assignment of Yes. Otherwise, the in-network benefits will follow the CareFirst PPO network if the Medicare assignment is No. All other providers will be considered out of network.

Covered Services under the Medicare Complementary program are the same as under the Description of Covered Services; only the manner of payment is different.

A. **Coverage Secondary to Medicare**
Except where prohibited by law, CareFirst benefits are secondary to Medicare.

B. **Medicare as Primary**

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

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

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

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

a. Numerical Example for a Member who Elects Medicare Part B:

Numerical example, assuming: **Part B deductible has been met;** **CareFirst Deductible, if applicable, has been met;** **CareFirst Coinsurance of either 100% or 80%; and** **Medicare approved charge does not exceed limitation set by Medicare, if applicable**		**Member Pays:**
Medicare approved amount	$ 1,000.00	
Multiplied by 80% equals Medicare payment	$ 800.00	
Basis for CareFirst's payment (remaining 20% of the Medicare approved amount)	$ 200.00	
Multiplied by 100% CareFirst In-Network Coinsurance equals CareFirst payment of	$ 200.00	$0.00
OR multiplied by 80% CareFirst Out-of-Network Coinsurance equals CareFirst payment of	$ 160.00	20% Coinsurance (which in this example **equals** $40.00)

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

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

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

   c. Numerical Examples for a Member who Does not Elect Part B:

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

Numerical example, assuming: **The amount Medicare would have paid is not available;** **CareFirst Deductible, if applicable, has been met;** **CareFirst Coinsurance of either 100% or 80%**		**Member Pays:**
Health Care Provider's charge	$ 1,500.00	
CareFirst Allowed Benefit	$ 1,000.00	
Medicare payment	$ 0.00	
Basis for CareFirst's payment is 20% of Allowed Benefit	$ 200.00	
Multiplied by 100% CareFirst In-Network Coinsurance equals CareFirst payment of	$ 200.00	The difference between CareFirst's payment and the Allowed Benefit (which in this example **equals** $800.00)
OR multiplied by 80% CareFirst Out-of-Network Coinsurance equals CareFirst payment of	$ 160.00	20% Coinsurance **plus** the difference between CareFirst's payment and the Health Care Provider's charge (which in this example **equals** $1,340.00)

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

Numerical example, assuming: **The amount Medicare would have paid is not available;** **CareFirst Deductible, if applicable, has been met;** **CareFirst Coinsurance of either 100% or 80%**		**Member Pays:**
Health Care Provider's charge	$ 1,000.00	
CareFirst Allowed Benefit	$ 500.00	
Medicare payment	$ 0.00	
Basis for CareFirst's payment is 20% of Allowed Benefit	$ 100.00	
Multiplied by 100% CareFirst In-Network Coinsurance equals CareFirst payment of	$ 100.00	The difference between CareFirst's payment and the Allowed Benefit (which in this example **equals** $400.00)
OR multiplied by 80% CareFirst Out-of-Network Coinsurance equals CareFirst payment of	$ 80.00	20% Coinsurance **plus** the difference between CareFirst's payment and the Health Care Provider's charge (which in this example **equals** $920.00)

DESCRIPTION OF COVERED SERVICES

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

PREVENTIVE AND WELLNESS SERVICES

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. CareFirst will also provide 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). At a minimum, benefits for preventive services listed in this provision will be provided once per Benefit Period.

Benefits are available as follows:

A. Adult preventive services

Benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Breast cancer screening, mammography, and prevention benefits shall be available in accordance with current USPSTF recommendations rated "A" or "B."

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

B. Child preventive and routine care

With respect to infants, children, and adolescents, benefits are available in accordance with the most recent guidelines of the American Academy of Pediatrics and for evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

C. Immunizations

Benefits are available for immunizations, including Influenza vaccinations, and shingles (herpes zoster) vaccination,* that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. Benefits include exam and immunizations required for school admissions.

*Shingles vaccination benefits are limited to Members fifty (50) years old and older.

D. Chlamydia and Human Papillomavirus Screening

1. Definitions

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

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

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

2. Covered Services

a. An annual routine Chlamydia Screening Test.

b. A human papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.

E. Colorectal Cancer Screening

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

F. Breast Cancer Screening

At a minimum, benefits will be provided for breast cancer screening as stated in the Schedule of Benefits. 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.

Coverage under this provision includes coverage for digital tomosynthesis, that under the accepted standard in the practice of medicine, the Member's treating physician determines that it is Medically Necessary for the Member. As used in this provision, "digital tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross–sectional digital three–dimensional images of the breast.

G. Osteoporosis Prevention

1. Definitions

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

Qualified Individual means a Member:

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

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

c. Receiving long term glucocorticoid (steroid) therapy;

d. With primary hyperparathyroidism; or

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

2. Covered Services

Bone Mass Measurement for the prevention and diagnosis of osteoporosis when requested by a Health Care Provider for a Qualified Individual.

H. Prostate Cancer Screening

Benefits are available for the detection of prostate cancer. Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal exams:

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

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

3. When used for staging in determining the need for a bone scan for patients with prostate cancer; or

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

I. Lung Cancer Screening

At a minimum benefit will be provided for lung cancer screening in accordance with the recommendations of the United States Preventive Services Task Force (USPSTF).

AMBULANCE SERVICES
(EMERGENCY AND NON-EMERGENCY)

In addition to Ambulance Services as stated in the Emergency Services and Urgent Care section and the Organ and Tissue Transplant section of this Evidence of Coverage, Medically Necessary air/sea transportation and ground ambulance services, between Health Care Provider facilities.

APPLIED BEHAVIOR ANALYSIS SERVICES

Benefits are available for Applied Behavior Analysis services, as such services are defined in this Evidence of Coverage.

COMPLEX CHRONIC OR HIGH RISK ACUTE DISEASE MANAGEMENT

Complex chronic or high risk acute disease management benefits are available as follows:

A. Definitions

Chronic Care Coordination Program (CCC Program) means the assessment and coordination of primary care services to a Qualified Member with multiple chronic and severe health conditions.

Complex Case Management Program (CCM Program) means the assessment and coordination of specialty services provided to a Qualified Member with advanced or critical illnesses.

Designated Provider means a provider contracted with CareFirst to provide services under CareFirst's Total Care and Cost Improvement Program, which includes the following components: PCMH Program, CCM Program, CCC Program, Comprehensive Medication Review, Enhanced Monitoring Program, Expert Consultation Program, Home-Based Services Program, Hospice and Palliative Care Program, Pharmacy Coordination Program, Substance Abuse and Behavioral Health Program, or other community-based programs outlined in this section (collectively, the "TCCI Programs") and who has agreed to participate in care coordination activities in cooperation with CareFirst for Qualified Members with complex chronic disease or high risk acute conditions.

Qualified Member means a Member who:

1. Is accepted by CareFirst into one or more of the TCCI Programs described in this section. CareFirst will consult with the Member's treating physician or nurse practitioner to determine whether the Member has a medical condition that meets the parameters for participation in one or more of the TCCI Programs.

2. Consents to participate and complies with all elements of the TCCI Program(s) in which he/she qualifies including use of a Designated Provider.

3. Continues to meet the criteria for participation in the TCCI Program(s) and participates fully with any applicable plan of care or other requirements, including compliance with direction from a PCP or Specialist while under a plan of care.

4. CareFirst and the Qualified Member's treating physician or nurse practitioner determine is cooperating with, and satisfying the requirements of the TCCI Program(s). CareFirst retains final authority to determine whether a Member is a Qualified Member.

B. Benefits

1. Qualified Members are eligible for the following CCM Program and CCC Program benefits when prescribed as part of a plan of care:

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

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

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

   d. Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Member's care;

e. Assistance in arranging consultation(s) with Specialists;

f. Identification of and connection to community resources, and other organizations/support services to supplement the Qualified Member's plan of care;

g. Implementation of a plan of care under the direction of the Qualified Member's treating physician or nurse practitioner.

h. Coordination of care, either telephonically or otherwise, between a Designated Provider and a Qualified Member and his/her treating physician.

i. Other Medically Necessary services provided to a Qualified Member as part of a plan of care.

2. Qualified Members are eligible for benefits under following TCCI Program elements:

a. Comprehensive Medication Review (CMR). Benefits will be provided for a Pharmacist's review of medications and consultation with the Qualified Member to improve the effectiveness of pharmaceutical therapy.

b. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Member with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Member's chronic condition or disease.

c. Expert Consultation Program (ECP). Benefits will be provided for a review by a team of Specialists of a Qualified Member's medical records where the Qualified Member has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

d. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in a home-based care management plan.

Covered Services provided to a Qualified Member pursuant to a home-based care management plan under this section will not count toward any Home Health Care visit limits stated in the Schedule of Benefits.

e. Hospice and Palliative Care Program. Benefits will be provided for medical and associated services specifically outlined in a hospice/palliative plan of care.

f. Pharmacy Coordination Program. Benefits will be provided for care coordination services related to a Qualified Member's use of Specialty Drugs.

g. Substance Abuse and Behavioral Health Program. Benefits will be provided for care coordination services related to a Qualified Member's use of mental health and substance use disorder services, including behavioral health treatment benefits.

3. Qualified Member Cost Sharing Responsibilities.

a. If the Qualified Member has funded his/her HSA account during the calendar year, then the Qualified Member will be responsible for any associated costs for services under this section until the annual Deductible has been met, unless the Covered Services appear on the list of preventive services maintained by the Internal Revenue Service.

4. Termination

a. The Qualified Member's participation in the TCCI Program(s) and receipt of benefits under this section will be terminated under the following circumstances:

1) The Qualified Member completes the stated goals of the TCCI Program(s) set forth in the Qualified Member's plan of care and confirmed by the Qualified Member's treating physician or nurse practitioner or, if the TCCI Program(s) benefits are provided outside of a plan of care, when confirmed by the Qualified Member's treating physician or nurse practitioner.

2) The CareFirst designated nurse, provider, or care coordinator and the Qualified Member's treating physician or nurse practitioner determine that the Qualified Member failed to comply with the TCCI Program(s) and/or any related plan of care or treatment under this section. The Qualified Member will be given thirty (30) days prior written notice of termination under this subsection.

3) The Qualified Member's coverage under the Evidence of Coverage is terminated.

b. If termination is the result of the Qualified Member's failure to comply with the TCCI Program(s) under paragraph B.4.a.2), the Qualified Member will be provided the opportunity to comply with the TCCI Program(s) during the thirty (30) day notice period. If after consultation between the Qualified Member's treating physician or nurse practitioner and the CareFirst designated nurse, provider, or care coordinator a determination is made that the Qualified Member is not and will not be compliant with the applicable TCCI Program(s), the Qualified Member will receive a final written notice of termination of benefits under this section.

c. Upon termination of the Qualified Member's participation in the TCCI Program(s), all benefits shall be null and void on and after the effective date of termination and the Qualified Member will be responsible for any and all cost-sharing responsibilities as stated in the Schedule of Benefits on and after the effective date of termination..

CONTROLLED CLINICAL TRIAL PATIENT COST COVERAGE

Controlled Clinical Trial Patient Cost benefits are available as follows:

A. Definitions

Controlled Clinical Trial means a treatment that is:

1. Approved by an institutional review board;

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

3. Is approved by:

   a. The National Institutes of Health (NIH) or a Cooperative Group.

   b. The Centers for Disease Control and Prevention.

   c. The Agency for Health Care Research and Quality.

   d. The Centers for Medicare & Medicaid Services.

   e. Cooperative group or center of any of the entities described in clauses 3.a) through 3.d) above or the Department of Defense or the Department of Veterans Affairs.

   f. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.

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

      1) To be comparable to the system of peer review of studies and investigations used by the NIH, and

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

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

   i. 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.

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

Multiple Project Assurance Contract means a contract between an institution and the federal 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.

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

B. Covered Services

1. Benefits will be provided to a Member in a Controlled Clinical Trial if the Member's participation in the Controlled Clinical Trial is the result of:

   a. Treatment provided for a life-threatening condition; or,

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

2. Coverage will be provided only if:

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

   b. 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;

   c. 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;

   d. There is no clearly superior, non-Experimental/Investigational treatment alternative; and,

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

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

DIABETES-RELATED SERVICES

A. Covered Services:

1. Coverage will be provided for all Medically Necessary and medically appropriate equipment when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy or consistent with the American Diabetes Association's standard, elevated or impaired blood glucose levels induced by prediabetes.

2. Coverage will be provided for all Medically Necessary and medically appropriate Diabetes Supplies when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy or consistent with the American Diabetes Association's standard, elevated or impaired blood glucose levels induced by prediabetes.

   a. Diabetes Supplies also includes Medical Supplies prescribed to treat Members diagnosed with diabetes for the purpose of preventing the exacerbation of their chronic condition.

3. Coverage will be provided for all Medically Necessary and medically appropriate diabetes outpatient self-management training and educational services, including medical nutrition therapy, as follows:

   a. When deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

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

EMERGENCY SERVICES AND URGENT CARE

A. Covered Services

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

   a. Emergency Services includes post-stabilization services provided by Non-Preferred Health Care Providers, as part of outpatient observation or an inpatient stay related to the Member's Emergency Medical Condition, unless:

      1) The attending emergency physician or Treating Health Care Provider determines that the Member is able to travel using non-medical transportation (non-ambulance) or non-emergency medical transportation (non-emergency ambulance) to an available Preferred Health Care facility located within a reasonable travel distance, taking into consideration the Member's medical condition; and

      2) The Health Care Provider providing the post-stabilization services to the Member, satisfies the Notice and Consent Requirements, stated in the How the Plan Works section of this Evidence of Coverage, and the Notice and Consent satisfies the following additional criteria:

         a) If the post-stabilization services are being provided by a Non-Preferred Health Care Provider in a Preferred Health Care facility, the written notice must include:

            (1) A list of Preferred Health Care Providers at the Emergency Facility who are able to provide the post-stabilization services needed by the Member; and

            (2) Notification that the Member may be referred, at the Member's option, to a Preferred Health Care Provider;

         b) If the post-stabilization services are being provided at a Non-Preferred Emergency Facility, the written notice must include the good faith estimated amount that the Member may be charged for the services provided by the Non-Preferred Health Care Provider; and

         c) The Treating Health Care Provider or attending emergency physician has determined that the Member, or the Member's Authorized Representative are in a condition to receive the notice and provide informed consent to the receive the services from the Non-Preferred Health Care Provider.

2. Urgent Care services.

3. Follow-up care after emergency surgery.

4. Ambulance Services, as stated in this Description of Covered Services.

B. Limitations

1. Follow-up care after emergency surgery is limited to Covered Services provided by the Health Care Provider who performed the surgical procedure. The Member will be responsible for the same copayment for each follow-up visit as would be required for a visit to an In-Network Health Care Provider for specialty care.

EXPERT CONSULTATION PROGRAM

A. Definitions

Expert Consultation Program (ECP) means the CareFirst Program for Members with a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

B. Covered Services

Benefits for review of a Member's medical records by a team of specialists will be provided to a Member, without an active plan of care, who qualifies under the ECP as determined by CareFirst. The review of the Member's medical records will be done in accordance with the ECP.

GENDER REASSIGNMENT SURGERY

A. Requirements

1. For Adult Members (18 years of age or older): Gender incongruence in adult (18 years of age or older), as indicated by ALL of the following:

   Benefits for gender incongruence in adult (18 years of age or older) are available when indicated by ALL of the following:

   a. Marked and sustained gender incongruence as assessed and documented by clinician experienced in care of transgender and gender-diverse (TGD) people.

   b. Gender incongruence not due to reversible cause (e.g., psychosis).

   c. Patient able to grant informed consent (able to understand risks of adverse events, complications, procedure options, benefits, irreversibility, and reproductive impact).

   d. No physical or mental illness that will interfere with adherence to short-term and long-term postoperative treatment.

   e. Stable on gender-affirming hormone treatment (GAHT) for at least six (6) months unless contraindicated, not necessary, or not desired (depending on the surgical procedure, longer periods of GAHT may be necessary in order to provide the best surgical result).

   f. Social transition (e.g., name change, pronoun change, communication of affirmed gender identity to others) in place or judged by clinician to be unnecessary (e.g., nonbinary gender identity).

   g. Gender-affirming procedure(s) are needed, as follows:

      1) Masculinization or defeminization procedure, as indicated by one (1) or more of the following:

         (a) Chest (top) surgery (e.g., mastectomy, masculinizing chest surgery.

         (b) Genital surgery (e.g., metoidioplasty, phalloplasty, scrotoplasty, vaginectomy, testicular prosthesis, penile prosthesis).

         (c) Hysterectomy with or without oophorectomy.

         (d) A Facial masculinization, when existing appearance varies significantly from that of experienced gender (e.g., rhinoplasty, facelift, contouring or augmentation of jaw, chin, forehead.

         (e) Other aesthetic procedure when existing appearance varies significantly from that of experienced gender (e.g., body contouring).

         (f) Voice procedure (e.g., vocal cord injection, thyroplasty type III) if testosterone therapy and voice training insufficient.

      2) Feminizing or demasculinizing procedure, as indicated by one (1) or more of the following:

         (a) Breast augmentation (after completion of estrogen therapy induced native breast development).

(b) Genital surgery (e.g., vaginoplasty, vulvoplasty).

(c) Orchiectomy.

(d) Facial and neck feminization, when existing appearance varies significantly from that of experienced gender (e.g., brow reduction, chondrolaryngoplasty, rhinoplasty, hair removal, contouring or augmentation of jaw, chin, forehead).

(e) Other aesthetic procedure when existing appearance varies significantly from that of experienced gender (e.g., body contouring, hair removal).

(f). Voice procedure (e.g., glottoplasty, laryngoplasty, cricothyroid approximation, laser- assisted voice adjustment).

*For Hormone Treatment: Authorization for continuation therapy must meet ALL initial authorization criteria for a period not less than six (6) months.

*Written documentation: Written documentation from a board-certified Behavioral Health specialist is **not** required for adult Members (18 years old or older).

2. For adolescent Members (13 to 17 years of age):

Benefits for gender incongruence in adolescent (13 to 17 years of age) are available when indicated by ALL of the following:

a. Marked and sustained gender incongruence as assessed and documented by clinician experienced in care of transgender and gender-diverse (TGD) adolescents.

b. Gender incongruence not due to reversible cause (e.g., psychosis).

c. Patient judged to have emotional and cognitive maturity required to provide informed assent for treatment.

d. No mental health concerns that may interfere with diagnostic clarity or capacity to assent.

e. Legal guardians (e.g., parents, assigned guardians) able to grant informed consent (able to understand risks of adverse events, complications, procedure options, benefits, and irreversibility) unless involvement is harmful or not possible.

f. No physical or mental illness that will interfere with adherence to short-term and long-term postoperative treatment.

g. Social transition e.g., name change, pronoun change, communication of affirmed gender identity to others) in place or judged by clinician to be unnecessary (e.g., nonbinary gender identity).

h. Gender-affirming procedure(s) are needed, as follows:

1) Chest (top) surgery (e.g., mastectomy, masculinizing chest surgery) needed due to persistent chest dysphoria (discomfort and distress from unwanted breast development).

2) Other gender-affirming procedure (e.g., breast augmentation, orchiectomy, vaginoplasty, hysterectomy, metoidioplasty, facial surgery) as indicated by ALL of the following:

(a) Surgery judged appropriate and necessary to address gender incongruence by multidisciplinary clinical team experienced in transgender and gender-diverse adolescents.

(b) At least twelve (12) months of gender-affirming hormone therapy (longer, if required, to achieve desired surgical result).

*For Hormone Treatment: Authorization for continuation therapy must meet ALL initial authorization criteria for a period not less than twelve (12) months.

*Written documentation: Written documentation is required for adolescent Members (13 to 17 years of age).

- The letter should be from a board-certified Behavioral Health specialists (i.e., psychiatrist or psychologist who is trained and has experience in transgender care).

The letter should address the following:

- Capacity to understand the benefits and potential complications from transgender surgery and ability to make an informed decision and assent.
- The absences of mental health conditions that would interfere with the ability to give informed assent or interfere with postoperative treatment compliance.

B. Covered Services

1. The gender reassignment surgeries that may be performed for transwomen Members (male to female) that meet the above criteria may include but are not limited to:

   a. Clitoroplasty: creation of clitoris.

   b. Facial feminization: Facial bone reduction: contouring or augmentation of jaw, forehead and brow reduction.

   c. Labiaplasty: creation of labia.

   d. Laryngoplasty: reshaping of laryngeal framework (voice modification surgery).

   e. Mammoplasty: breast augmentation.

   f. Orchiectomy: removal of testicles.

   g. Penectomy: removal of penis.

   h. Prostatectomy: removal of prostate.

   i. Trachea shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage.

   j. Urethroplasty: creation of urethra.

   k. Vaginoplasty: creation of vagina.

   l. Voice modification surgery/Cricothyroid approximation: voice modification that raises the vocal pitch by stimulating contractions of the cricothyroid muscle with sutures.

   m. Vocal cord injection, thyroplasty type III) if testosterone therapy and voice training are insufficient. Laser -assisted voice adjustment.

   n. Vulvoplasty: creation of vulva.

*Note: these procedures are generally accepted as part of transgender care but in some cases may be deemed cosmetic (e.g. request for second breast revisions) and are thus subject to medical director review.

2. The gender reassignment surgeries that may be performed for transmen (female to male) that meet the above criteria include, but are not limited to:

   a. Hysterectomy: removal of uterus Mastectomy: removal of the breast.

   b. Metoidioplasty: creation of micro-penis using the clitoris Penile prosthesis: penile implant.

   c. Phalloplasty: creation of penis, with or without urethra.

   d. Salpingo-oophorectomy: removal of fallopian tubes and ovaries Scrotoplasty: creation of scrotum.

   e. Testicular prosthesis: implantation of artificial testes.

   f. Urethroplasty: creation of urethra within penis.

   g. Vaginectomy: removal of vagina.

   h. Vulvectomy: removal of vulva.

   i. Other surgeries for assisting in body feminization or body masculinization are generally labeled Cosmetic as they provide no significant improvement in physiologic function. However, these surgeries can be considered Medically Necessary depending on the unique clinical situation of a given patient's condition. These surgeries include but are not limited to:

      1) Blepharoplasty: removal of redundant skin of the upper and/or lower eyelids and protruding periorbital fat.

      2) Chin augmentation reshaping or enhancing the size of the chin (Genioplasty).

      3) Gluteal augmentation via implants and lipofilling.

      4) Hair removal via electrolysis, laser, and waxing/Hair transplantation.

      5) Lip reduction/enhancement: decreasing/enlarging lip size.

      6) Lipofilling.

      7) Liposuction/Lipoplasty: removal of fat and/or body contour modeling.

      8) Pectoral implants.

      9) Rhinoplasty: reshaping of the nose.

      10) Rhytidectomy: face lift.

C. Cancer Screenings

Professional organizations such as the American Cancer Society, American College of Obstetricians and Gynecologists and the U.S. Preventive Services Task Force provide recommended preventive and cancer screening guidelines to facilitate clinical decision-making by professional providers. Gender specific screenings may be medically necessary for transgender persons appropriate to their anatomy.

Examples include:

- Cervical cancer screening may be medically necessary for transmen persons who have not undergone a hysterectomy.
- Breast cancer screening may be medically necessary for transmen persons who have not undergone a mastectomy.
- Prostate cancer screening may be medically necessary for transwomen persons who have retained their prostate.

According to the DSM-5-TR (2022), the requirements for adults and adolescents include having Gender Dysphoria for at least six (6) months and expressing clinically significant distress or impairment in social, occupational, or other important areas of functioning as evidenced by at least **two** (2) of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

GENERAL ANESTHESIA FOR DENTAL CARE

A. Covered Services

1. 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:

   a. If the Member is:

      1) Seven (7) years of age or younger, or developmentally disabled;

      2) 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

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

   b. Or, if the Member is:

      1) Seventeen years of age or younger;

      2) An extremely uncooperative, fearful, or uncommunicative individual;

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

      4) An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.

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

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

      1) A fully accredited specialist in pediatric dentistry;

      2) A fully accredited specialist in oral and maxillofacial surgery; and

      3) A dentist who has been granted hospital privileges.

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

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

HOME HEALTH CARE

A. Covered Services

1. Home Health Care, as defined in this Evidence of Coverage.

2. Home Visits Following Childbirth, including any services required by the attending Health Care Provider:

   a. For a Member and newborn Dependent child(ren) who remain in the hospital for at least forty-eight (48) hours after an uncomplicated vaginal delivery, or ninety-six (96) hours after an uncomplicated cesarean section:

      1) One (1) home visit following childbirth, if prescribed by the attending Health Care Provider.

   b. For a Member and her newborn Dependent child(ren) who, in consultation with the Member's attending Health Care Provider, requests a shorter hospital stay (less than forty-eight (48) hours following an uncomplicated vaginal delivery or ninety-six (96) hours following an uncomplicated cesarean section):

      1) One (1) home visit following childbirth scheduled to occur within twenty-four (24) hours after discharge; and

      2) One (1) additional home visit following childbirth if prescribed by the attending Health Care Provider.

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

   d. Home visits following childbirth must be rendered, as follows:

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

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

3. Home Visits Following a Mastectomy

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

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

      2) One (1) additional home visit if prescribed by the Member's attending physician.

   b. For a Member who remains in the hospital for at least forty-eight (48) hours following a mastectomy, coverage will be provided for one (1) home visit if prescribed by the Member's attending physician.

4. Home Visits Following the Surgical Removal of a Testicle

a. For a Member who receives less than forty-eight (48) hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis:

1) One (1) home visit following the surgical removal of a testicle scheduled to occur within twenty-four (24) hours after discharge; and

2) One (1) additional home visit following the surgical removal of a testicle if prescribed by the attending physician.

B. Limitations

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

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

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

4. The Member must require and continue to require Skilled Nursing Care or Rehabilitative Services in order to qualify for home health aide services or other types of Home Health Care.

HOSPICE CARE

A. Definitions

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

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

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

B. Covered Services

Hospice Care Program benefits are available for a terminally ill Member (medical prognosis by a physician that the Member's life expectancy is six months or less) when the Member is under the care of a PCP or other Health Care Provider.

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

Additionally, hospice care benefits are available for a Member's family and/or Caregiver, as follows:

1. Periodic family counseling before the Member's death.
2. Bereavement counseling.

INFERTILITY SERVICES

A. Definitions

Infertility means the inability to conceive under the conditions determined below.

Benefits are available for the diagnosis and treatment of infertility including Medically Necessary, non-Experimental/Investigational artificial insemination/intrauterine insemination, in vitro fertilization and fertility drugs administered as a part of in vitro fertilization treatment, as follows:

B. Covered Services:

1. Artificial Insemination and Intrauterine Insemination

a. Benefits are available when:

1) For a Member whose Spouse is of the opposite sex:

a) The Member and the Member's Spouse have a history of the inability to conceive after one (1) year of unprotected vaginal intercourse and the Member's Spouse's sperm is used; and,

b) The Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination; and,

c) The Member's Spouse's sperm is used.

2) For a Member whose Spouse is of the same sex, the Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination.

3) For a Member who does not have a partner, the Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination.

b. Benefits will not be provided for costs incurred by the Member in obtaining donor sperm/eggs.

2. 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.

2) The unmarried Member or 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 sex, an inability to conceive after at least one (1) year of unprotected vaginal intercourse failing to result in pregnancy; or

b) If the Member and the Member's Spouse are of the same sex, three (3) attempts of artificial insemination over the course of one (1) year failing to result in pregnancy; or

c) If the Member who does not have a partner, three (3) attempts of artificial insemination over the course of one (1) years failing to result in pregnancy; or

3) The infertility is associated with any of the following medical conditions:

a) Endometriosis;

b) Exposure in utero to diethylstilbestrol, commonly known as DES;

c) Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or

d) Abnormal male factors, including oligospermia, contributing to the infertility.

4) The Member has been unable to attain a successful pregnancy through less costly infertility treatment for which coverage is available under this Agreement; and

5) 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. For the unmarried Member or the Member whose Spouse is of the opposite sex, any charges associated with the collection of e 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. For a Member who does not have a partner, benefits will not be provided for costs incurred by the Member in obtaining donor sperm.

3. References in this subsection to a "Member" includes the legally married Dependent children of Subscribers.

4. Fertility Prescription Drugs for artificial insemination/intrauterine insemination and in vitro fertilization.

INPATIENT/OUTPATIENT HEALTH CARE PROVIDER SERVICES
(Ambulatory Services; Hospitalization; Laboratory Services)

A. Covered Services

1. Inpatient medical care and consultations.

2. Outpatient medical care and consultations, including:

   a. Telemedicine Services:

      1) Benefits are available for the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the Member at a site other than the site where the Member is located ("Telemedicine Services").

      2) Telemedicine Services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a Health Care Provider and a Member.

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

4. Inpatient and outpatient surgery, as follows:

   a. Medically Necessary surgical procedures, as determined by CareFirst.

   b. 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.

   c. Oral surgery, limited to:

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

      2) Surgery involving a bone, joint or soft tissue of the face, neck or head to treat a condition caused by accidental injury and trauma, as follows:

         a) In the event there are alternative procedures that meet generally accepted standards of professional care for a Member's condition, benefits will be based upon the lowest cost alternative.

         b) Coverage will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if:

            (1) The injury did not arise while or as a result of biting or chewing; and

c) Benefits are limited to 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.

5. Inpatient assistant if the surgery requires surgical assistance as determined by CareFirst.

6. Outpatient surgical assistant if the surgery requires surgical assistance as determined by CareFirst.

7. Inpatient surgical anesthesia services by a Health Care Provider other than the operating surgeon.

8. Outpatient anesthesia services by a Health Care Provider other than the operating surgeon.

9. Inpatient chemotherapy.

10. Outpatient chemotherapy, including Prescription Drugs benefits for orally administered chemotherapy.

11. Outpatient Infusion Therapy.

12. Infusion Therapy in the home.

13. Inpatient inhalation therapy.

14. Outpatient inhalation therapy.

15. Inpatient radiation therapy.

16. Outpatient radiation therapy.

17. Inpatient renal dialysis.

18. Outpatient renal dialysis.

19. Inpatient diagnostic services, including:

    a. Laboratory tests.

    b. X-ray and radiology services.

    c. Diagnostic specialty imaging and other diagnostic services.

    d. Non-Preventive Diagnostic Breast Examinations and Supplemental Breast Examinations. Diagnostic Breast Examinations includes an examination using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound. Supplemental breast examination includes an examination using breast magnetic resonance imaging or breast ultrasound.

    e. Non-preventive follow-up diagnostic imaging of the lungs to assist in the diagnosis of lung cancer for individuals for which the screening is recommended by the U.S Preventive Services Task Force. Coverage includes diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image guided biopsy.

20. Outpatient diagnostic services, including:

    a. Laboratory tests.

    b. X-ray and radiology services.

    c. Diagnostic specialty imaging and other diagnostic services.

    d. Non-Preventive Diagnostic Breast Examinations and Supplemental Breast Examinations. Diagnostic Breast Examinations includes an examination using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound. Supplemental breast examination includes an examination using breast magnetic resonance imaging or breast ultrasound.

    e. Non-preventive follow-up diagnostic imaging of the lungs to assist in the diagnosis of lung cancer for individuals for which the screening is recommended by the U.S Preventive Services Task Force. Coverage includes diagnostic ultrasound, magnetic resonance imaging, computed tomography, and image guided biopsy.

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

22. Acupuncture for chronic pain management.

23. Allergen immunotherapy (allergy injections).

24. Allergy testing.

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

26. Inpatient or outpatient benefits for cleft lip or cleft palate or both, as follows:

    a. Oral surgery.

    b. Orthodontics.

    c. Otologic, audiological and speech/language treatment.

27. Female elective sterilization.

28. Male elective sterilization.

29. Skilled Nursing Facility services.

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

31. Treatment of temporomandibular joint (TMJ) dysfunction: Medically Necessary conservative treatment and surgery, as follows:

Covered for the result of congenital and developmental anomalies; fractures and dislocations resulting from trauma; masticatory muscle disorders, joint abnormalities or other pathologic conditions including internal derangement, ankylosis (stiffening or fixation of a joint), or arthritic and neoplastic diseases, as well as parafunctional (dental) habit.

32. Family planning services, including contraceptive counseling.

    a. Contraceptive counseling benefits include instruction on Fertility Awareness–Based Methods rendered by a licensed health care provider.

33. Evaluation and Medically Necessary management services of flat foot conditions.

34. Coverage will be provided for the Medically Necessary diagnosis, evaluation and treatment of lymphedema, including complex decongestive therapy and self-management training and education.

35. Medically Necessary diagnostic services and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including but not limited to intravenous immunoglobulin therapy.

MASTECTOMY-RELATED SERVICES

A. Covered Benefits

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

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

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

4. Home Health Care services, as stated in the "Home Health Care" services subsection of this Description of Covered Services.

MATERNITY SERVICES AND NEWBORN CARE

A. Covered Services

1. Health Care Provider services, including:

a. Maternity services:

1) Preventive prenatal services, as follows:

a) Outpatient obstetrical care of an uncomplicated pregnancy, including pre-natal evaluation and management office visits, one (1) post-partum office visit, and breastfeeding support, supplies and consultation as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration; and

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

2) Other outpatient obstetrical care and professional services for all prenatal, delivery and post-partum complications, including, but not limited to, prenatal and post-partum office visits not specifically identified above, and Ancillary Services provided during those visits. These benefits include Medically Necessary laboratory diagnostic tests and services not identified above, but are not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis;

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

b. Newborn care services, if child is enrolled as stated in the Eligibility Schedule, as follows:

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

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

3) Circumcision, including circumcision performed by a mohel recognized under the laws of Judaism.

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

1) A minimum of:

a) Forty-eight (48) hours following an uncomplicated vaginal delivery;

b) Ninety-six (96) hours following an uncomplicated cesarean section.

2) Up to four (4) additional days of routine nursery care of the newborn child(ren) when the Member is required to remain in the hospital for Medically Necessary reasons.

2. Elective abortions.

3. Coverage for victims of rape or incest.

4. Birthing centers.

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

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

B. Maternity services are available to all female Members.

C. Newborn care services and inpatient hospital services for newborn child(ren), including routine nursery care of the newborn child, are not available for the newborn child of a Dependent child (i.e., a grandchild), unless grandchildren are eligible for Dependent coverage, as determined by the Group.

MEDICAL DEVICES AND SUPPLIES

A. Definitions

Durable Medical Equipment means equipment which:

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

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

Medical Device means:

1. Durable Medical Equipment.
2. Hearing Aids.
3. Medical Supplies.
4. Orthotic Devices and Prosthetic Devices.

Medical Supplies means items that:

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

Orthotic Device means orthoses and braces which:

1. Are primarily and customarily used to serve a therapeutic medical purpose;
2. Are prescribed by a Health Care Provider;
3. Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;

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

5. Include devices necessary for post-operative healing.

Prosthetic Device means a device which:

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

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

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

4. Is prescribed by a Health Care Provider; and

5. Is removable and attached externally to the body.

B. Covered Services

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

Coverage includes Medically Necessary equipment for the treatment of lymphedema and ostomies.

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

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

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

3. **Hearing Aids**
Benefits for adult Members and minor Dependent children are available under a separate Hearing Care Rider purchased by the Group and attached to the Evidence of Coverage.

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

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

Coverage includes Medically Necessary Medical Supplies for the treatment of lymphedema, including Gradient Compression Garments.

Gradient Compression Garment means a garment that:

1. Is used for the treatment of lymphedema;

2. Requires a prescription; and

3. Is custom fit for the Member for whom the garment is prescribed.

Gradient Compression Garment does not include disposable Medical Supplies, including Over-the-Counter compression or elastic knee-high or other stocking products.

Coverage also includes Medically Necessary Medical Supplies for the treatment of ostomies.

6. **Orthotic and Prosthetic Devices**

a. Benefits for Prosthetic Devices except for prosthetic leg(s), arm(s) or eye(s), are as follows:

1) Medically Necessary Prosthetic Devices

2) Supplies and accessories necessary for effective functioning of a covered Prosthetic Device.

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

3) Replacement of covered Prosthetic Devices when repairs or adjustments fail and/or are not possible.

4) Repair of covered Prosthetic Devices.

b. Benefits for Prosthetic leg(s), arm(s) or eyes, are as follows:

1) Coverage shall be provided for Prosthetic Devices which replace, in whole or in part, a leg, an arm or an eye.

2) Coverage includes:

a) Components of prosthetic leg, arm or eye; and

b) Repairs to prosthetic leg, arm or eye.

3) Requirements for Medical Necessity for coverage of a prosthetic leg, arm or eye will not be more restrictive that the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

c. Benefits for Orthotic Devices, are as follows:

1) Medically Necessary Orthotic Devices.

2) Supplies and accessories necessary for effective functioning of a covered Orthotic Device.

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

4) Replacement of covered Orthotic Devices when repairs or adjustments fail and/or are not possible.

5) Repair of covered Orthotic Devices.

d. Limitations:

1) Benefits for the repair, maintenance or replacement of a covered Device require authorization or approval by CareFirst.

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

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

4) Replacement coverage is limited to once every two (2) benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the Device on the part of the Member or of a family member are not covered.

7. **Contraceptive Devices**
Contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider. The insertion or removal, and any Medically Necessary examination associated with the use of a contraceptive device are also Covered Services (Please see the Inpatient/Outpatient Health Care Provider Services subsection of this Evidence of Coverage for a description of the insertion and removal Covered Services).

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

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

1. **Inpatient services**
   Benefits are provided when the Member is admitted as an inpatient to a hospital or other health care facility for the treatment of mental illness, emotional or behavioral disorders, or substance use disorders, as follows:

   a. Hospital or inpatient facility benefits, as described in the "Inpatient/Outpatient Health Care Provider Services" section of this Description of Covered Services.

2. **Residential Crisis Services**
   Benefits are provided Medically Necessary Residential Crisis Services.

3. **Outpatient services**
   Benefits are available for outpatient treatment of mental illness, emotional or behavioral disorders, or substance use disorder, including:

   a. Outpatient services for the diagnosis, care, and treatment of mental health and substance use disorders, including behavioral health treatment.

   b. Partial Hospitalization services.

   c. Psychological and neuropsychological testing for diagnostic purposes.

   d. Methadone maintenance treatment.

   e. Visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy.

4. **Applied Behavior Analysis services**
   Benefits are available for Applied Behavior Analysis services, as such services are defined in this Evidence of Coverage.

ORGAN AND TISSUE TRANSPLANTS

A. Definitions

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

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

B. Recipient/Donor Services

If a Member under this Evidence of Coverage is:	**Services are available as follows:**
The organ transplant recipient	Benefits are available for both the Member recipient and the non-Member donor. Donor Services benefits are available under this Evidence of Coverage only to the extent that benefits are not available from another source, such as other group health plan coverage or health insurance plan.
The organ transplant donor	No transplant benefits are available for non-Member recipients. No Donor Services benefits are available under this Evidence of Coverage for the Member-donor, unless the organ transplant recipient is also a Member.

C. Covered Services

1. Medically Necessary, non-Experimental/Investigational solid organ transplant procedures and bone marrow or other non-solid organ transplant procedures, and Related Services.

   Benefits will be provided for high dose chemotherapy/bone marrow or stem cell transplant treatment that is not Experimental/ Investigational as determined by CareFirst.

2. Donor Services, limited to the extent stated above.

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

4. Immunosuppressant maintenance Prescription Drugs when prescribed for a covered transplant, as stated in the Prescription Drugs section of this Description of Covered Services.

5. Organ transplant procurement benefits for the recipient, as follows:

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

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

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

6. Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant hospital is over fifty (50) miles from the recipient's home. In order to receive travel benefits, a companion must be at least eighteen (18) years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under eighteen (18) years of age, there may be two companions.

D. Additional requirements
The organ transplant hospital must:

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

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

3. Be approved by CareFirst.

At least thirty (30) days before the start of a planned organ transplant the recipient's physician must give CareFirst written notice including:

1. Proof of Medical Necessity;

2. Diagnosis;

3. Type of surgery; and

4. Prescribed treatment.

OUTPATIENT PRIVATE DUTY NURSING

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

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

PATIENT-CENTERED MEDICAL HOME

A. Definitions

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

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

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

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

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

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

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

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

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

B. Covered Services

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

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

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

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

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

C. Limitations

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

PRESCRIPTION DRUGS

A. Covered Services

1. Prescription Drugs dispensed in the office/place of service of a Health Care Provider.

   a. Benefits are available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office/place of service of a Health Care Provider.

   b. Injectable Prescription Drugs that require administration by a Health Care Provider.

   c. Allergenic extracts (allergy sera).

   d. Immunosuppressant maintenance Prescription Drugs when prescribed for a covered transplant.

2. Pharmacy-dispensed Prescription Drugs:

   a. Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs, except for benefits provided under the Prescription Drugs Benefits Rider for Special Population Members.

3. All other Medically Necessary Prescription Drugs.

PROFESSIONAL NUTRITIONAL COUNSELING/MEDICAL NUTRITION THERAPY

A. Definitions

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, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a registered licensed dietitian or other eligible Health Care Provider, as determined by CareFirst.

Medical Nutrition Therapy, provided by a registered dietitian, 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 such as cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizure disorders (e.g., ketogenic diet), and other conditions based on the efficacy of diet and lifestyle on the treatment of these disease states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a Member's food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

B. Covered Services

Benefits are available for Professional Nutritional Counseling, to include Medical Nutrition Therapy services, when Medically Necessary as determined by CareFirst.

REHABILITATIVE AND HABILITATIVE SERVICES

A. Covered Services

1. **Inpatient Rehabilitative Services**
   Benefits are available for inpatient Rehabilitative Services when Medically Necessary.

2. **Outpatient Rehabilitative Services**
   Benefits are available for the following outpatient Rehabilitative Services:

   a. Occupational Therapy;

   b. Physical Therapy; and

   c. Speech Therapy.

3. **Cardiac Rehabilitation**
   Benefits for Cardiac Rehabilitation are provided to a Member who has been diagnosed with angina pectoris or who has recently suffered a heart attack within the past 12 months, had coronary artery bypass graft (CABG surgery), angioplasty, heart valve surgery, stable angina pectoris, compensated heart failure or undergone a Heart, Heart-Lung, Single/Double Lung Organ Transplant.

   All services must be Medically Necessary as determined by CareFirst in order to be covered. Services must be provided at a CareFirst-approved place of service equipped and approved to provide Cardiac Rehabilitation.

   Benefits will not be provided for maintenance programs.

4. **Habilitative Services (Dependent child through the end of the month in which the Member turns 19 years old)**

   a. Benefits for Habilitative services will be provided for Members until at least the end of the month in which the Member turns nineteen (19) years old.

   b. Benefits for Habilitative Services will be provided for Members, including:

      1) Occupational Therapy, Physical Therapy, and Speech Therapy.

      2) Applied Behavior Analysis services for autism or an autism spectrum disorder.

5. **Pulmonary Rehabilitation**
   Benefits are provided to Members who have been diagnosed with significant pulmonary disease, as defined by CareFirst, or, who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation.

   Benefits will not be provided for maintenance programs.

6. **Visual Therapy**
   Benefits are available for outpatient visual therapy.

SURGICAL TREATMENT OF MORBID OBESITY

A. Definitions

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

Morbid Obesity means:

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

2. 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.

NIH means the National Institutes of Health.

B. Covered Services

Benefits are provided for the surgical treatment of Morbid Obesity. The procedures must be recognized by the NIH as effective for the long-term reversal of Morbid Obesity and consistent with guidelines approved by the NIH and deemed Medically Necessary by CareFirst.

EXCLUSIONS

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

CareFirst will not provide a benefit for:

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

- Services that are not described as Covered Services or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a In-Network Health Care Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.

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

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

  This exclusion does not apply to:

  1. Medicaid;

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

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

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

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

- Cosmetic services (except for Mastectomy—Related Services Related Services, Covered Services as stated in the Gender Dysphoria Services section of the Description of Covered Services and services for cleft lip or cleft palate or both).

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

- All non-prescription drugs, medications, and biologicals routinely obtained and self-administered by the Member, unless stated in the Description of Covered Services.

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

- Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex, except as stated in the Gender Dysphoria Services subsection of the Description of Covered Services.

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

- Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment other than Medically Necessary and approved pulmonary and/or cardiac rehabilitation programs.

- Treatment for weight reduction and obesity, except for the surgical treatment of Morbid Obesity (see Description of Covered Services) and Weight Loss Programs as defined in this Evidence of Coverage.

  This exclusion does not apply to the treatment of childhood obesity, as required by the Patient Protection and Affordable Care Act.

- Routine vision examinations, including but not limited to external examination of the eye and adnexa, ophthalmoscopic examination, determination of refractive status, binocular balancing testing, tonometry test for glaucoma, gross visual field testing, and color vision testing.

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

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

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

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

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

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

- Educational therapies intended to improve academic performance.

- Vocational rehabilitation and employment counseling.

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

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

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

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

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

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

- Services intended to increase the intelligence quotient (IQ) of Members with an intellectual disability or to provide cure for primary developmental disabilities, if such services do not fall within generally accepted standards of medical care.

- Services for the purpose of controlling or overcoming delinquent, criminal, or socially unacceptable behavior unless deemed Medically Necessary by CareFirst.

- Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related.

- Services related to human reproduction other than specifically described in this Evidence of Coverage including, but not limited to maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a Member who is covered under this Evidence of Coverage as (a) an eligible employee or eligible participant of the Group or (b) as the eligible Spouse, eligible child.

- Blood products and whole blood when donated or replaced.

- Oral surgery, dentistry or dental processes unless otherwise stated, including removal or replacement of teeth, crowns, bridges, implants, orthodontics except cleft palate, the operation or treatment for the fitting or wearing of dentures, periodontal therapy, direct or indirect restorations (fillings) root canal therapy, treatment of dental cysts and abscesses.

- Premarital exams.

- Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.

- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.

- Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust, or a similar entity.

- Services rendered or available under any Workers' Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a Member is exempt from the above laws, the benefits of this Evidence of Coverage will be provided for Covered Services.

- Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain.

- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.

- Exams and related services, and completion of forms, required solely for: employment, pre-employment screening, insurance, foreign travel, travel requirements, school, camp admissions/scouting programs, participation in sports activities (sports physicals), pre-adoption, adoption, pre-foster parenting, foster parenting, admission to old age home, driving license including commercial driving license, handicapped tag documentation, immigration and naturalization, marriage, prison, disability examination, FMLA verification, Workers' Compensation, attorney forms, or attendance for issue of medical certificates.

- Immunizations solely for foreign travel.

- Charges used to satisfy a Member's dental care, Prescription Drug, or vision care benefits deductible, if applicable, or balances from any such programs.

- Financial and/or legal services.

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

- Hearing care except as otherwise stated.

- Tinnitus maskers, purchase, examination, or fitting of Hearing Aids, except as stated in the Description of Covered Services.

- Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst.

- Work Hardening Programs. Work Hardening Programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

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

CareFirst will not provide a benefit for:

Preventive and wellness services
- Out-of-network sexually transmitted infection counseling.

Ambulance (Emergency and Non-Emergency) Services
- Except Medically Necessary, non-emergency ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

Emergency Services and Urgent Care
- Except for covered ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

Gender dysphoria services
Cryopreservation, storage, and thawing of reproductive tissue (i.e., oocytes, ovaries, testicular tissue) and the charged associated therewith (e.g., office, hospital, ultrasounds, laboratory tests, etc.) are not covered.

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

Home Health Care
- Rental or purchase of renal dialysis equipment and supplies.
- "Meals-on-Wheels" type food plans.
- Domestic or housekeeping services.
- Care that, after training by skilled personnel, can be rendered by a non-Health Care Provider, such as one of the Member's family or a friend (changing dressings for a wound is an example of such care).

Hospice care
- Any services other than palliative treatment.
- Rental or purchase of renal dialysis equipment and supplies.
- Domestic or housekeeping services.
- "Meals on Wheels" or similar food arrangements.

Infertility services: Artificial Insemination and Intrauterine Insemination

- When the Member or Spouse has undergone elective sterilization with or without reversal.

- Surrogates and gestational carriers are not covered in any case.

- For a Member whose Spouse is of the opposite sex, when the service involves the use of donor egg(s), donor sperm or donor embryo(s).

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

- When the Member does not meet the conditions of coverage as described in the Infertility Services section of the Description of Covered Services.

- For AI/IUI, benefits will not be provided for any self-administered fertility drug (including Over-the-Counter medications) that not listed as a Covered Service in the Description of Covered Services.

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

Infertility services: In-vitro fertilization

- When the Member or Significant Other has undergone elective sterilization with or without reversal.

- Surrogates and gestational carriers are not covered in any case.

- For a Member whose Significant Other is of the opposite sex, when the service involves the use of donor egg(s), donor sperm or donor embryo(s).
- When the service involves the participation of a common law Spouse, except in states that recognize the legality of those relationships.

- When the Member does not meet the conditions of coverage as described in the Infertility Services section of the Description of Covered Services.

- For IVF, benefits will not be provided for any self-administered fertility drug (including Over-the-Counter medications) that are not listed as a Covered Service in the Description of Covered Services.

  Additionally, in-vitro fertilization benefits do not include benefits for cryopreservation, storage, and or thawing of sperm, egg(s), or embryo(s).

Inpatient/outpatient Health Care Provider services

- Medical care for inpatient stays that are primarily for observation, except for post-stabilization Covered Services, as stated in the Emergency Services section of the Description of Covered Services or as otherwise stated in this Evidence of Coverage.

- Medical care for inpatient stays that are primarily for diagnostic services, except as stated in this Evidence of Coverage.

- Medical care for inpatient stays that are primarily for Rehabilitative Services, except as stated in the Description of Covered Services.

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

- Acupuncture, except for acupuncture for chronic pain management as stated in the Description of Covered Services.

- Inpatient Private Duty Nursing.

- Telemedicine Services, except as stated in the Description of Covered Services.

- Procedures to reverse sterilization.

- Surgical removal of impacted teeth.

Medical Devices and Supplies

- Cranial molding orthoses for positional/deformational/non-synostotic plagiocephaly or brachycephaly.

- Durable Medical Equipment, except as stated in the Description of Covered Services.

- Durable Medical Equipment or supplies associated or used in conjunction with non-covered items or services.

- Medical Supplies, except as stated in the Description of Covered Services, or any riders attached to this Evidence of Coverage.

- Orthotic Devices, except as stated in the Description of Covered Services.

- Prosthetic Devices, except as stated in the Description of Covered Services.

- Food and formula consumed as sole source or supplemental nutrition except as stated in the Description of Covered Services.

- Transcutaneous electroneural stimulators (TENS).

- Breastfeeding supplies, except for supplies that are directly related to the operation of breast pumps.

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

- Marital counseling.

- Wilderness programs.
- Boarding schools.

Organ and tissue transplants

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

Prescription Drugs

- Outpatient Prescription Drugs, except as stated in the Description of Covered Services.
- Routine immunizations and boosters (except as stated in the Description of Covered Services, Preventive and Wellness Services).
- Prescription Drugs covered under the Group's prescription plan benefits.
- Prescription Drugs excluded under the Group's prescription plan benefits except as specifically stated in this Evidence of Coverage.
- Rabies vaccination.

Rehabilitative and Habilitative Services

- Services delivered through early intervention and school services.
- Habilitative Services for a Member after the last day the month in which the Member turns 19 years old.

ELIGIBILITY SCHEDULE FOR NON-MEDICARE OPTION

ELIGIBILITY		
The following persons meeting the eligibility requirements established by the Group are eligible for Exclusive Provider Organization benefits and Vision Care benefits under this Evidence of Coverage:		
Subscriber	A person eligible under guidelines defined by the Group including Medicare-eligible retiree under the terms of the Group's retirement program, as amended from time to time who was covered as a wage-earning employee before retirement.	
Spouse	Coverage for a Dependent Spouse, including a Medicare-eligible Dependent Spouse, is available.	
Domestic Partner	Coverage for a Domestic Partner is available. Domestic Partner coverage includes coverage for Medicare-eligible Domestic Partners.	
Dependent biological children, Dependent adopted children, or Dependent step-children	Coverage for Dependent biological children, Dependent adopted children, or Dependent step-children, including biological children, Dependent adopted children, or Dependent step-children of a Domestic Partner, is available.	**Limiting Age** Up to age 26
Dependent grandchildren, Dependent step-grandchildren, Dependent legal wards, or other Dependent child relatives	Coverage for Dependent grandchildren, Dependent step-grandchildren, Dependent legal wards, or other Dependent child relatives, including Dependent grandchildren, Dependent step-grandchildren, Dependent legal wards, or other Dependent child relatives of a Domestic Partner, is available.	**Limiting Age** Up to age 25
Unmarried incapacitated Dependent children	A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if: 1. The Dependent child is permanently disabled; 2. The Dependent child is unable to be self-supporting due to a mental or physical handicap or disability; 3. The Dependent child is primarily dependent on the Subscriber for support; 4. The Subscriber provides to the Group (or CareFirst if the Group so elects) proof of the Dependent child's permanent disability within sixty (60) days of the date coverage would have otherwise ended because the child reached a certain age. Once a certification of permanent disability is accepted by the Group, the accepted certification is valid for the duration of the Dependent child's lifetime; 5. Upon the Group's request, the Subscriber provides proof of the Dependent child's continued disability; and 6. The onset of disability must have occurred before the child reached age 26.	**Limiting Age** Not applicable

ELIGIBILITY		
The following persons meeting the eligibility requirements established by the Group are eligible for Exclusive Provider Organization benefits and Vision Care benefits under this Evidence of Coverage:		
	Proof of permanent disability may require medical examinations provided at the Group's expense. Proof will not be required more than once a year. If proof of disability is not provided within sixty (60) days, benefits will not be available for the Dependent child under this Evidence of Coverage. If all the requirements above are met, coverage for the Dependent child under this Evidence of Coverage will continue as long as the Dependent child is incapacitated and dependent on the Subscriber, unless coverage is otherwise terminated in accordance with the terms of the Plan. Proof of disability is not required until the Dependent child reaches age 26.	
Individuals covered under prior continuation provision	Coverage for a person whose coverage was being continued under a continuation provision of the Group's prior health insurance plan is available.	
	Coverage for a person whose coverage was being continued under a continuation provision of the Subscriber's prior health insurance plan is available.	

EFFECTIVE DATES OF COVERAGE	
Open Enrollment	The Group's Contract Date is the effective date of Coverage.
Newly eligible Subscriber	A new Subscriber is eligible for coverage effective on the first (1st) of the month after date of hire. If hired on the first of the month, date of hire as stated in the definition of Effective Date. Within sixty (60) days of an employee taking or returning from an unpaid leave of absence (Family and Medical Leave Act of 1993) a new Subscriber is eligible for coverage effective the first (1st) of the month as stated in the definition of Effective Date. A Subscriber who is not enrolled when CareFirst receives a Qualified Medical Support Order is eligible for coverage effective on the date specified in the Medical Child Support Order. If a Section 125 Plan, within sixty (60) days after any event which, in the judgment of the Plan Administrator qualifies as a status change or other allowable change under Section 125 of the Internal Revenue Code (family status changes) a new Subscriber is eligible for coverage effective the first of the month depending on when the first payroll deduction is taken as stated in the definition of Effective Date. **Retroactive Effective Date:** The first (1st) of the month following the Subscriber's date of hire or the date the Subscriber returns from an unpaid leave of absence or the date of the qualifying event.
Dependents of a newly eligible Subscriber	Dependents of a newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective as follows: Dependent Spouse: the first (1st) of the month following the date of the event. Child Dependent: Date of birth, adoption, placement for adoption, court order, or testamentary appointment. **Retroactive Effective Date:** The first (1st) of the month following the Subscriber's date of hire or the date the Subscriber returns from an unpaid leave of absence or the date of the qualifying event.
Individuals whose coverage was being continued under the Group's prior health insurance plan	The Group's Contract Date.
Dependents of the individual being continued under the individual's prior health insurance plan	An individual will be effective as stated in "Dependents of a newly eligible Subscriber."

SPECIAL ENROLLMENT PERIODS	
Special enrollment for certain individuals who lose coverage (not applicable to retirees, if retirees are eligible for coverage)	The employee must notify the Group, and the Group must notify CareFirst no later than 60 days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least 60 days after a claim is denied due to the operation of a lifetime limit on all benefits. A new Subscriber and/or his/her Dependent(s) is effective as follows: In the case of loss of coverage due to death of Spouse or Spouse's involuntary termination from employment: the first (1st) of the month following date of event. In the case of loss of other coverage and Subscriber qualifies as a special enrollee: the first (1st) of the month following acceptance of the enrollment by CareFirst.
Special enrollment for certain dependent beneficiaries	The employee must notify the Group, and the Group must notify CareFirst during the sixty (60) day special enrollment period beginning, as follows: A new Subscriber and/or his/her Dependents is effective as follows: In the case of marriage: the first (1st) of the month following the date of the event. In the case of a newly born child: the date of birth (or, if Dependent coverage is not generally available at the time of the birth, a period of thirty (30) days after Dependent coverage is made generally available by the Group). In the case of an adopted child: the date of adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent (or, if Dependent coverage is not generally available at the time of the adoption or the placement for adoption, a period of thirty (30) days after Dependent coverage is made generally available by the Group).
Special enrollment regarding Medicaid and CHIP termination or eligibility	The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act. The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan). A new Subscriber and/or his/her dependents are effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.

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

SCHEDULE OF BENEFITS FOR NON-MEDICARE OPTION

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

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

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

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

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

Covered Service(s); and

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

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

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

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

COPAYS	
Primary Care Provider (PCP)	**Specialist**
A $15 per visit Copay applies to Covered Services by a provider with a specialty of:	A $25 per visit Copay applies to Covered Services by all other practitioners.
Family practice; General practice; Geriatrics; Gynecology; Internal Medicine; Obstetrics/Gynecology; Pediatrics; Nurse Practitioner.	

DEDUCTIBLE: Out-of-Network Only	
Individual	**Family**
$250	$500
Deductible applicable to out-of-network Covered Services, except as stated in the Schedule of Benefits.	
The Deductible is calculated based on the Allowed Benefit of Covered Services.	
When the Type of Coverage is Individual, CareFirst will pay for all or part of remaining Covered Services when the Member reaches the Individual Deductible amount. When the Type of Coverage is Family, the Family Deductible amount is calculated by combining the amounts contributed by all the family Members covered under the Family Type of Coverage. CareFirst pays benefits for a family Member in a Family Type of Coverage who reaches the Individual Deductible amount before the Family Deductible amount is reached. A family Member may not contribute more than the Individual Deductible amount to the Family Deductible amount.	
The following amounts apply to the Deductible:	The following amounts may not be used to satisfy the Deductible:
- 100% of the Allowed Benefit for Covered Services that are subject to the Deductible.	- Charges in excess of the Allowed Benefit. - Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days listed below. - Charges for Covered Services not subject to the Deductible.

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

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

OUT-OF-POCKET MAXIMUM				
	In-Network		Out-of-Network	
	Individual	Family	Individual	Family
Plan Year Out-of- Pocket Maximum	$1,000	$2,000	$3,000	$6,000

The family Out-of-Pocket Maximums are calculated in the aggregate.
A family Member may **not** contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.

CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Out-of-Pocket Maximum is met. Copays will be waived for the remainder of the Benefit Period.

All cost-share payments made by the Member for the following Covered Services will contribute towards the in-network Out-of-Pocket Maximum:

- Emergency Services provided by Non-Preferred Health Care Providers.
- Air Ambulance Services provided by Non-Preferred Health Care Providers.
- Non-emergency Covered Services provided by Non-Preferred Health Care Providers at Preferred Health Care facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Non-Preferred Health Care Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in the "How the Plan Works" of this Evidence of Coverage.
- Covered Services provided by a Preferred Health Care Provider, when the Member relied on a database, provider directory, or information provided by CareFirst regarding the Health Care Provider's status (through a telephone call or electronic means) which incorrectly indicated that the Health Care Provider was a Preferred Health Care Provider for the Covered Service received.

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

IMPORTANT NOTE REGARDING MEMBER'S COST-SHARE AND PAYMENT FOR CERTAIN COVERED SERVICES PROVIDED BY NON-PREFERRED HEALTH CARE PROVIDERS
Any Copayment, Coinsurance, and/or other cost-sharing requirement for services provided by Non-Preferred Health Care Providers **will be the same** as the Copayment, Coinsurance, and/or other cost-sharing requirement stated in this Schedule of Benefits for services provided by Preferred Health Care Providers, for the following Covered Services: • Emergency Services provided by Non-Preferred Health Care Providers. • Air ambulance services provided by Non-Preferred Health Care Providers. • Non-emergency Covered Services provided by Non-Preferred Health Care Providers at Preferred Health Care facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Non-Preferred Health Care Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in the "How the Plan Works" of this Evidence of Coverage. • Covered Services provided by a Preferred Health Care Provider, when the Member relied on a database, provider directory, or information provided by CareFirst regarding the Health Care Provider's status (through a telephone call or electronic means) which incorrectly indicated that the Health Care Provider was a Preferred Health Care Provider for the Covered Service received.

IMPORTANT NOTE REGARDING INTERNATIONAL OUTPATIENT PROFESSIONAL AND FACILITY SERVICES
The Allowed Benefit for outpatient professional practitioner services and facility services provided internationally will be the international provider's actual charge and benefits are available to the same extent as benefits provided for outpatient professional and outpatient facility services provided by Preferred Providers.

Covered Services	CareFirst Payment	
	In-Network	**Out-of-Network**
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Infant, child, and adolescent preventive and wellness services	**Limitations** Benefits for child preventive and routine care are limited to thirteen (13) visits for Members age newborn through thirty-six (36) months; thereafter, one (1) visit per Benefit Period.	
Office visit	100% of Allowed Benefit	80% of Allowed Benefit
Immunizations	Regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider 100% of Allowed Benefit	80% of Allowed Benefit
Diagnostic services		Hospital, Outpatient Professional, or Office 80% of Allowed Benefit
Adult preventive and wellness services	**Limitations** Benefits for adult preventive care are limited to one visit per Benefit Period. In-Network benefits for counseling for sexually transmitted infections are available for Members and limited to one (1) visit per Benefit Period. No Out-of-Network benefit is available for sexually transmitted infections counseling. Benefits for counseling and screening for interpersonal and domestic violence are available for Members and are limited to one (1) visit per Benefit Period.	
Office visit	100% of Allowed Benefit	80% of Allowed Benefit
Immunizations	Regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider 100% of Allowed Benefit	80% of Allowed Benefit
Diagnostic services(except Lung Cancer Screening; see below)		Hospital, Outpatient Professional, or Office 80% of Allowed Benefit
Colorectal cancer screening (including colonoscopy, flexible sigmoidoscopy)	Regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider 100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit

Covered Services	CareFirst Payment	
	In-Network	**Out-of-Network**
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Sexually transmitted infections screening and counseling (including, but not limited to, hepatitis C, chlamydia, and human papillomavirus (HPV) screenings)	**Limitations** Benefits for sexually transmitted infections screening and counseling are limited to one (1) screening and counseling service per Benefit Period. Benefits for Human Papillomavirus DNA testing are limited to one (1) HPV DNA testing every three (3) years for Members thirty (30) years old and older.	
	Regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider 100% of Allowed Benefit	No benefit
Breast cancer screening	**Limitations** Benefits for mammography screening are limited to one (1) screening every Benefit Period for Members thirty-five (35) years old and older.	
	Regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider 100% of Allowed Benefit	Hospital, Outpatient Professional, or Office No Deductible required 80% of Allowed Benefit
Lung cancer screening	Regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider 100% of Allowed Benefit	Hospital, Outpatient Professional, or Office No Deductible required 80% of Allowed Benefit
Osteoporosis prevention	Regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider 100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit
Prostate cancer screening	Regardless of whether billed by same Health Care Provider as office visit or different Health Care Provider 100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit
Flu Shots	100% of Allowed Benefit	No benefit
Subsequent treatment of a condition diagnosed during a preventive and wellness services office visit (treatment for which is not included in preventive and wellness services benefits)	Benefits are available to the same extent as benefits provided for other illnesses.	
Primary purpose of the office visit is not the delivery of preventive and wellness services		
Office visit and, if not billed separately, preventive and wellness services	100% of Allowed Benefit after the appropriate per visit Copay	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Ambulance Services (Emergency and Non-Emergency)	**Limitations** Ambulance services (ground, surface, air, and sea) are limited, as follows: • Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance.	
Emergency Ambulance Services	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Non-Emergency Ambulance Services	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Applied Behavior Analysis services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Complex Chronic or High Risk Acute Disease Management	**Limitations** Home Health Care hospital/home health agency visit limit does not apply to Home-Based Services Program (HBS). Benefits will be provided as described in the Description of Covered Services for Complex Chronic or High Risk Acute Disease Management or Patient-Centered Medical Home Program.	
Services provided pursuant to a plan of care	100% of Allowed Benefit	No benefit
TCCI Program elements		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Controlled Clinical Trials Patient Costs	**Limitations** Hospital Pre-Certification and Review is required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

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

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Emergency Services and Urgent Care		
Emergency Services in a hospital emergency room/department* **		
Hospital emergency room/ department and Ancillary Services routinely available to the emergency room/department to evaluate an Emergency Medical Condition	100% of Allowed Benefit after $100 Copay*	No Deductible required 100% of Allowed Benefit after $100 Copay*
Outpatient professional practitioner(s) in hospital emergency room/department	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Member admitted as inpatient	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department		
Office (except diagnostic or surgical services performed in an office)	100% of Allowed Benefit after appropriate per visit Copay**	80% of Allowed Benefit
Diagnostic or surgical services performed in an office	Benefits are available to the same extent as benefits provided for non-preventive outpatient diagnostic services.	
Urgent Care center	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Dental services related to accidental injury or trauma	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit

*Copay waived if admitted. Member pays one (1) copay per hospital emergency room/emergency department visit, regardless of number of days.
**Copay applies to office exam only.
***To determine the CareFirst Payment for Covered Services provided outpatient professional practitioner Covered Services in an emergency room/department, the claim will be suspended for five (5) days from the date of receipt until the corresponding facility claim is received. Once the facility claim is received, the outpatient professional practitioner claim will be paid as Emergency Services if the facility claim was for Emergency Services; the outpatient professional practitioner claim will be paid as illness medical care and consultation (i.e., non-Emergency Services) if the facility claim was for non-Emergency Services. If no corresponding facility claim is submitted, the CareFirst Payment for outpatient professional practitioner Covered Services will be determined solely on the outpatient professional practitioner claim.
Note: Benefits for HIV testing performed in a hospital emergency room are not subject to the Deductible.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Expert Consultation Program	100% of Allowed Benefit	No benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Gender Dysphoria Services	**Limitations** Hospital PreCertification & Review is required for inpatient services. Pre-authorization is required for outpatient services. Benefits for gender dysphoria services are limited to the extent provided in the Description of Covered Services.	
Outpatient psychotherapy/mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses	Benefits are available to the same extent as benefits provided for other inpatient Covered Services, outpatient Covered Services, and Prescription Drug Covered Services.	
Continuous hormone replacement therapy		
Outpatient laboratory testing to monitor continuous hormone therapy		
Gender reassignment surgery		
Augmentation mammoplasty (including breast prosthesis if necessary)		
Post gender reassignment benefits		

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

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Home Health Care	**Limitations** An approved Plan of Treatment is required for Home Health Care. Hospital/home health agency: One-hundred and twenty (120) days of unlimited Home Health Care Visits per Benefit Period. Home health aid: Forty (40) Home Health Care Visits per Benefit Period.	
Hospital/home health agency	100% of Allowed Benefit	80% of Allowed Benefit
Home visits following childbirth	Home Health Care Visit limits, if any, do not apply.	
	100% of Allowed Benefit	80% of Allowed Benefit
Home visits following mastectomy	Home Health Care Visit limits, if any, do not apply.	
	100% of Allowed Benefit	80% of Allowed Benefit
Home visits following the surgical removal of a testicle	Home Health Care Visit limits, if any, do not apply.	
	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Hospice care	**Limitations** An approved Plan of Treatment is required for hospice care; the Plan of Treatment must be accepted in writing by the Member and/or family. There must be a willing and able Caregiver available. Respite Care is limited to a maximum of fourteen (14) days per Benefit Period. At the discretion of CareFirst, Respite Care may be limited to five (5) consecutive days for each inpatient stay. Bereavement counseling is limited to the six (6) month period following the Member's death or fifteen (15) visits, whichever occurs first.	
Facility/agency	100% of Allowed Benefit	80% of Allowed Benefit
Respite care		
Bereavement counseling		
Family counseling		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Infertility services		
Artificial insemination (AI)/ intrauterine insemination (IUI)	**Limitations** Prior authorization is required. Benefits for artificial insemination (AI) and/or intrauterine insemination (IUI) are limited to six (6) attempts per live birth.	
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	
Office	100% of Allowed Benefit after $25 Copay	
In vitro fertilization (IVF)	**Limitations** Prior authorization is required. Benefits for in vitro fertilization (IVF) are limited to three (3) attempts per live birth.	
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after $25 Copay	
Office	100% of Allowed Benefit after $25 Copay	
Fertility Prescription Drugs for artificial insemination/intrauterine insemination and in vitro fertilization	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Inpatient Health Care Provider Services	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient hospital or health care facility	**Limitations** Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
	100% of Allowed Benefit	80% of Allowed Benefit
Skilled Nursing Facility	**Limitations** Hospital Pre-Certification and Review is required. Skilled Nursing Facility services are limited to 180 days per Benefit Period.	
	100% of Allowed Benefit	80% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery (including radiologists*, pathologists, anesthesiologists*, and surgical assistants)	100% of Allowed Benefit	80% of Allowed Benefit

*If the anesthesiologist is Non-Contracting, the claim will be suspended until the facility claim is received not to exceed 30 days. If the facility is Contracting upon receipt of claim, the anesthesiology claim will be paid in-network (100%). If the facility is Non-Contracting upon receipt of claim, the anesthesiology claim will be paid out-of-network (80% after deductible). If the facility claim is not received within 30 days, the claim will default to the out-of-network benefit (80% after deductible).

If the radiologist is Non-Contracting, the claim will be suspended until the facility claim is received not to exceed 30 days. If the facility is Contracting upon receipt of claim, radiology claim will be paid in-network (100%). If the facility is Non-Contracting upon receipt of claim, radiology claim will be paid out-of-network (80% after deductible). If the facility claim is not received within 30 days, the claim will default to the out-of-network benefit (80% after deductible).

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient/Outpatient Health Care Provider Services		
Contraceptive exam, insertion and removal	100% of Allowed Benefit	No benefit
Cleft lip or cleft palate, or both		
Oral surgery		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit	80% of Allowed Benefit
Office	100% of Allowed Benefit after appropriate per visit Copay	80% of Allowed Benefit
Orthodontics (office)	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Otological, audiological and speech/language treatment	Rehabilitative Services visit limits for Speech Therapy, if any, do not apply.	
Hospital	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit	80% of Allowed Benefit
Office	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Family planning services		
Contraceptive counseling (except for fertility awareness-based methods)	100% of Allowed Benefit	No benefit
Fertility Awareness-Based Methods contraceptive counseling	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Treatment of flat foot conditions	**Limitations** Benefits are limited to the evaluation and Medically Necessary management services only.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mastectomy-related services	Benefits are available to the same extent as benefits provided for other illnesses.	
Home visits following mastectomy	Home Health Care Visit limits, if applicable, do not apply.	
	See Home Health Care	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Maternity services and newborn care	**Limitations** Benefits for gestational diabetes screening are available between 24-28 weeks gestation.	
Maternity services and newborn care except preventive prenatal services	Benefits are available to the same extent as benefits provided for other illnesses.	
Preventive Prenatal Services	100% of Allowed Benefit	80% of Allowed Benefit
Lactation support and counseling	100% of Allowed Benefit	No Benefit
Breastfeeding supplies and equipment	**Limitations** Benefits for breast pumps and supplies directly related to the operation of breast pumps are only covered when provided by In-Network Durable Medical Equipment providers. The breast pumps and supplies directly related to the operation of breast pumps are not covered Out-of-Network. All other breastfeeding supplies are not covered.	
	100% of Allowed Benefit	No Benefit
Circumcision by a Mohel	No benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Medical Devices and Supplies		
Durable Medical Equipment	100% of Allowed Benefit	80% of Allowed Benefit
Hair prosthesis	**Limitation** Benefits are limited to one (1) hair prosthesis per Benefit Period.	
	100% of Allowed Benefit	80% of Allowed Benefit
Hearing Aids	Benefits are available as stated in the Hearing Care Rider.	
Non-routine services related to the Hearing Aid dispensing	Benefits are available to the same extent as benefits provided for other illnesses.	
Medical foods and nutritional substances	100% of Allowed Benefit	80% of Allowed Benefit
Medical Supplies	100% of Allowed Benefit	80% of Allowed Benefit
Orthotic Devices, Prosthetic Devices (except leg, arm, and eye)	100% of Allowed Benefit	80% of Allowed Benefit
Orthotic Devices; Prosthetic Devices, leg, arm, eye	100% of Allowed Benefit after $15 Copay	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Mental health and substance use disorder services, including behavioral health treatment	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient Health Care Provider Services	**Limitations** Hospital Pre-Certification and Review is required.	
	Benefits are available to the same extent as Inpatient Health Care Provider services benefits provided for other illnesses.	
Outpatient Health Care Provider Services (except outpatient methadone maintenance treatment)	Benefits for outpatient care are available, including: • Partial hospitalization; • Intensive outpatient services; • psychological and neuropsychological testing for diagnostic purposes; and • visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy.	
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit	
Office	100% of Allowed Benefit after $15 Copay	
Outpatient methadone maintenance treatment	**Limitations** Member payment for methadone maintenance will not be greater than 50% of its daily cost.	
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit	
Office	100% of Allowed Benefit after $15 Copay	
Emergency Services	Benefits are available to the same extent as Emergency Services benefits for other illnesses.	
Prescription Drugs	Benefits are available to the same extent as Prescription Drug benefits for other illnesses.	
Telemedicine Services for mental health and substance use disorder services, including behavioral health treatment		
Video visits provided by Designated Virtual Care Provider	Benefits are available to the same extent as benefits for face-to-face outpatient mental health and substance use disorder services office visits, stated above.	No benefit
Telephonic consultations (audio-only)	Benefits are available to the same extent as benefits for face-to-face outpatient mental health and substance use disorder services office visits, stated above.	
Other Telemedicine Services	Benefits are available to the same extent as benefits for face-to-face outpatient mental health and substance use disorder services office visits, stated above.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Non-Preventive Outpatient Diagnostic Services		
Laboratory tests and X-Rays		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner*		
Office		
Outpatient Non-Preventive Diagnostic Breast Examinations and Supplemental Breast Examinations		
Outpatient department of a hospital	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Independent/Freestanding facility		
Outpatient professional practitioner		
Follow-up diagnostic imaging of the Lungs (including diagnostic image-guided biopsy of the lungs for cancer)		
Outpatient department of a hospital	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Independent/Freestanding facility		
Outpatient professional practitioner		

*If the radiologist is Non-Contracting, the claim will be suspended until the facility claim is received not to exceed 30 days. If the facility is Contracting upon receipt of claim, radiology claim will be paid in-network (100%). If the facility is Non-Contracting upon receipt of claim, radiology claim will be paid out-of-network (80% after deductible). If the facility claim is not received within 30 days, the claim will default to the out-of-network benefit (80% after deductible).

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Observation Services		
Observation room via the emergency room within one (1) day	100% of Allowed Benefit after $100 Copay	No Deductible required 100% of Allowed Benefit after $100 Copay
Observation room by way of and including the emergency room services of greater than one (1) day or more	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Organ and tissue transplants	**Limitations** Benefits are limited to the extent stated in the Organ and Tissue Transplant subsection of the Description of Covered Services. Organ transplant travel benefits are limited to sixty (60) days per transplant. Travel benefits are limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. Pre-authorization is required for outpatient bone marrow transplants.	
Organ and tissue transplants	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant procurement		
Organ transplant travel	100% of Allowed Benefit*	No Deductible required 100% of Allowed Benefit*

*The Allowed Benefit is the actual charge.

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Outpatient Health Care Provider Services		
Medical care and consultations (illness visits)		
Outpatient hospital/facility	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit after the appropriate per visit Copay	80% of Allowed Benefit
Office	100% of Allowed Benefit after the appropriate per visit Copay	80% of Allowed Benefit
Retail Health Clinic	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Urgent Care center	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Illness visit to a hospital emergency room/department (not Emergency Services)*	50% of Allowed Benefit after $100 Copay	No Deductible required 50% of Allowed Benefit after $100 Copay
Illness visit to a hospital emergency room/department (not Emergency Services) Outpatient professional practitioner(s) in hospital emergency room/department	50% of Allowed Benefit	No Deductible required 50% of Allowed Benefit
Telemedicine Services	Benefits are available to the same extent as benefits for telephonic consultations for other illnesses as stated in the "Medical Care and Consultations" section of this Schedule of Benefits.	
Video visits provided by Designated Virtual Care Provider	100% of Allowed Benefit after the appropriate per visit Copay	80% of Allowed Benefit
Telephonic consultations (audio-only)	100% of Allowed Benefit after the appropriate per visit Copay	80% of Allowed Benefit
Other Telemedicine Services	100% of Allowed Benefit after the appropriate per visit Copay	80% of Allowed Benefit
Routine outpatient hospital visits/clinic/other hospital services	100% of Allowed Benefit	80% of Allowed Benefit

*The Copay does not apply to surgical or diagnostic services rendered in a hospital emergency room/department during an illness visits (i.e., during a non-Emergency visit).

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Outpatient Surgical Services		
Surgery		
Outpatient hospital/facility	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit	80% of Allowed Benefit
Office	100% of Allowed Benefit after the appropriate per visit Copay	80% of Allowed Benefit
Ambulatory surgical facility services	100% of Allowed Benefit	80% of Allowed Benefit
Anesthesia	100% of Allowed Benefit	80% of Allowed Benefit
Surgical assistant	100% of Allowed Benefit	80% of Allowed Benefit
Female elective sterilization	100% of Allowed Benefit	No benefit
Male elective sterilization	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	

*If the anesthesiologist is Non-Contracting, the claim will be suspended until the facility claim is received not to exceed 30 days. If the facility is Contracting upon receipt of claim, the anesthesiology claim will be paid in-network (100%). If the facility is Non-Contracting upon receipt of claim, the anesthesiology claim will be paid out-of-network (80% after deductible). If the facility claim is not received within 30 days, the claim will default to the out-of-network benefit (80% after deductible).

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Acupuncture for chronic pain management	**Limitations** Preauthorization required.	
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Administration of injectable Prescription Drugs	100% of Allowed Benefit	80% of Allowed Benefit
Allergen immunotherapy (allergy injections) excluding the allergenic extracts (sera)	100% of Allowed Benefit	80% of Allowed Benefit
Allergenic extracts (sera)	100% of Allowed Benefit after the appropriate per visit Copay	80% of Allowed Benefit
Allergy testing	100% of Allowed Benefit after the appropriate per visit Copay	80% of Allowed Benefit
Chemotherapy		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		
Office		
Home Infusion Therapy	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Inhalation therapy		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		
Office		
Radiation therapy		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		
Office		
Renal dialysis		
Hospital	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		
Office		
Spinal manipulation/chiropractic services	**Limitations** Preauthorization required.	
Office	100% of Allowed Benefit after $20 Copay	80% of Allowed Benefit
Vision therapy (orthoptics/pleoptics)		
Office	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Private Duty Nursing	**Limitations** An approved Plan of Treatment is required. No inpatient Private Duty Nursing benefits are available.	
Facility/agency	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Prescription Drugs	**Limitations** Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits available through CareFirst for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.	
Prescription Drugs	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drugs that require administration by a Health Care Provider, except: • allergenic extracts (allergy sera) • Prescription Drug contraceptives and contraceptive devices	Benefits are available to the same extent as benefits provided for other illnesses.	
Prescription Drug contraceptives and contraceptive devices dispensed in the office of a Health Care Provider	100% of Allowed Benefit	No benefit

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

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Professional Nutritional Counseling/Medical Nutrition Therapy (non-routine)		
All outpatient places of service (including video visits provided by Designated Virtual Care Providers)	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Rehabilitative and Habilitative Services		
Inpatient Rehabilitative Services	**Limitations** Inpatient Rehabilitative Services are covered for when Medically Necessary. Hospital Pre-Certification and Review is required.	
	100% of Allowed Benefit	No benefit
Outpatient Rehabilitative Services	**Limitations** Benefits are limited to fifty (50) combined visits per Benefit Period for: • Occupational Therapy • Physical Therapy • Speech Therapy. A Plan of Treatment is required for Speech Therapy after the first (1st) visit. A Plan of Treatment is required for Physical Therapy after the twentieth (20th) visit per Benefit Period. A Plan of Treatment is required for Occupational Therapy after the twentieth (20th) visit per Benefit Period.	
Occupational Therapy	Visit limit, if any, does not apply to Habilitative Services Covered Services.	
Hospital	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit	80% of Allowed Benefit
Office	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Physical Therapy*	Visit limit, if any, does not apply to Habilitative Services Covered Services. *Physical Therapy provided by an acupuncturist will be available to same extent as Acupuncture services.	
Hospital	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit	80% of Allowed Benefit
Office	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Speech Therapy	Visit limit, if any, does not apply to Habilitative Services Covered Services.	
Hospital	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit	80% of Allowed Benefit
Office	100% of Allowed Benefit after $25 Copay	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative and Habilitative Services		
Outpatient Rehabilitative Services		
Cardiac Rehabilitation	**Limitations** An approved Plan of Treatment is required. Benefits are limited to a maximum of 36 sessions within a 12 week period per medical event with physician supervision. A physician referral is required.	
Hospital/facility	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner	100% of Allowed Benefit	80% of Allowed Benefit
Habilitative Services	**Limitations** An approved Plan of Treatment is required for Habilitative Services. Benefits are available for Members until the end of the month in which the Member turns nineteen (19) years old. Outpatient rehabilitative services visit limits, if any, do not apply to Habilitative Services Covered Services.	
	Benefits are available to the same extent as benefits provided for other outpatient services.	
Pulmonary Rehabilitation		
Hospital/facility	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		
Office		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Surgical treatment of Morbid Obesity	**Limitations** Benefits are limited to the extent stated in the Description of Covered Services. Pre-authorization is required for outpatient morbid obesity surgery.	
	Benefits are available to the same extent as surgical benefits provided for other illnesses.	

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

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

An independent licensee of the Blue Cross and Blue Shield Association

GROUP WELLNESS PROGRAM RIDER FOR NON-MEDICARE OPTION

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

This rider adds a Reward Program to the Evidence of Coverage that rewards Members for: 1) selecting a specific Primary Care Provider; 2) completing a Health Risk Assessment that the Member and Member's Health Care Provider may use to initiate healthy behavior; and 3) visiting the selected Health Care Provider to discuss the results of the Health Risk Assessment.

Members receive Rewards as described in section D., Reward.

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SECTION A DEFINITIONS

In addition to the definitions contained in the Evidence of Coverage to which this rider is attached, the underlined terms below, when capitalized, have the following meanings:

Health Risk Assessment means a questionnaire that asks about the Member's age, habits, recent test results and medical history.

Primary Care Provider (PCP) means a Preferred Provider, who is a health care practitioner in the following disciplines:

1. Family practice;
2. General practice;
3. Geriatrics;
4. Gynecology;
5. Internal Medicine;
6. Obstetrics/Gynecology;
7. Pediatrics;
8. Nurse Practitioner.

Except to satisfy the requirements of this Group Wellness Program Rider, election of a PCP is not required to receive other services under the Group's Evidence of Coverage.

Reward means the Reward provided to Eligible Members for the completion of the wellness activities set forth in section B of this rider.

SECTION B WELLNESS ACTIVITIES

1/1/2026 Members who successfully complete each of the following activities will receive the Reward stated below through 12/31/27.

1. An Eligible Member may earn a $0 copays for (a) PCPs, and (b) mental health and behavioral Specialists for Covered Services provided under this Evidence of Coverage by completing the following requirements:

a. The Eligible Member must select a PCP, if the Eligible Member has not already done so; and

b. Complete either the medical plan's or the Group's Health Risk Assessment plan.

2. An Eligible Member may earn a $5 reduction on Specialist copays for Covered Services provided under this Evidence of Coverage by completing the following requirements:

a. Complete the recommended age/gender specific routine health screenings as recommended by the Member's PCP stated in section D., below. Based on the Member's age/gender, if there are no recommended age/gender appropriate screenings, the Member are exempt from the wellness requirements.

3. An Eligible Member may earn a $5 reduction on Specialist copays for Covered Services provided under this Evidence of Coverage by completing a Routine Annual Eye Exam.

SECTION C ELIGIBLE MEMBERS

Rewards earned in 2026 continue through 12/31/2027. The Groups Wellness Program applies to employees, Non-Medicare eligible enrolled Spouses. If the retiree is Medicare-eligible, but the Spouse is not, the Spouse is also exempt from the Group Wellness Program requirements. It does not apply to retirees (and retirees' Spouses) for who Medicare is primary nor does it apply to enrolled children even if they are adults.

SECTION D WELLNESS PROGRAM ROUTINE SCREENINGS

SCREENING	Member Age			
	18-29 YEARS	30-39 YEARS	40-49 YEARS	50-64 YEARS
ROUTINE CHECKUP • Personal history • Blood pressure • BMI • Physical exam • Comprehensive metabolic blood panel including LDL/ HDL, hemoglobin A1C	Annually	Every 1-3 Years, depending on risk factors	Every 1-3 Years, depending on risk factors	Annually
BREAST CANCER (Women)	Annual Clinical Breast Exam	Annual Clinical Breast Exam	Annual Clinical Breast Exam **And** Annual Mammography	Annual Clinical Breast Exam **And** Annual Mammography
CERVICAL CANCER	Initial Pap Test at 3 years after first sexual intercourse or by age 21. Then, every 1-3 years per clinician	Every 1-3 years per clinician (Pap test may be performed at 3 year intervals only after 3 consecutive negative results)	Every 1-3 years per clinician (Pap test may be performed at 3 year intervals only after 3 consecutive negative results)	Every 1-3 years per clinician (Pap test may be performed at 3 year intervals only after 3 consecutive negative results)
COLORECTAL CANCER	Not applicable	Not applicable	Not applicable	Colonoscopy at age 50, then once every 10 years **Or** As recommended by your physician
DIABETES – TYPE 2	Not applicable	Not applicable	Beginning at age 45: Every 3 years or more often at discretion of physician	Beginning at age 45: Every 3 years or more often at discretion of physician
TETANUS, DIPTHERIA IMMUNIZATION	3 doses if not previously immunized. Booster every 10 years (one booster should be with Adult dTap vaccine)	3 doses if not previously immunized. Booster every 10 years (one booster should be with Adult dTap vaccine)	3 doses if not previously immunized. Booster every 10 years (one booster should be with Adult dTap vaccine)	3 doses if not previously immunized. Booster every 10 years (one booster should be with Adult dTap vaccine)

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

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HEARING CARE RIDER FOR NON-MEDICARE OPTION

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

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

Benefits are available for:

1. Screening examination to diagnose hearing loss.

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

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

4. Hearing aids if:

    a. Basic standard model (behind the ear model);

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

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

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

Benefits are not provided for:

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

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

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

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

	CareFirst Payment	
Covered Service	**In-Network**	**Out-of-Network**
Hearing care	**Limitations** Benefits are limited to once per 3 years.	
Hearing aid evaluation test	100% of Allowed Benefit	80% of Allowed Benefit
Hearing aids (basic model for monaural/binaural)	100% of Allowed Benefit up to $5,000	80% of Allowed Benefit
Hearing exam/Audiometric tests	100% of Allowed Benefit after the appropriate per visit Copay	80% of Allowed Benefit
Hearing aid repair		
For Members who are minor children	100% of Allowed Benefit	100% of Allowed Benefit
For adult Members	100% of Allowed Benefit	80% of Allowed Benefit

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

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

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

An independent licensee of the Blue Cross and Blue Shield Association

VISION CARE BENEFITS RIDER FOR NON-MEDICARE OPTION

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

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SECTION A DEFINITIONS

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

Routine Vision Allowed Benefit means:

1. For a Participating Provider, the Routine Vision Allowed Benefit for a Covered Service is the lesser of:

   a. The actual charge; or

   b. The amount the Group CareFirst allows for the service in effect on the date that the service is rendered.

   The benefit is payable to the Participating Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.

2. For a Non-Participating Provider, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit payable to a Participating Provider. The benefit is payable to the Subscriber, or to the Non-Participating Provider, at the discretion of CareFirst. The Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the Non-Participating Provider's actual charge. It is the Member's responsibility to apply any CareFirst payments to the Non-Participating Provider's charges.

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

Non-Participating or Non-Par Provider means any Health Care Provider that does not contract with CareFirst.

Participating Provider or Par Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members.

SECTION B DESCRIPTION OF COVERED SERVICES

Benefits are available for:

1. A vision exam which may include:
    a. Case history;
    b. External exam of eye and adnexa;
    c. Ophthalmoscopic exams;
    d. Determination of refractive status;
    e. Binocular balance test;
    f. Tonometry test for glaucoma;
    g. Gross visual fields;
    h. Color vision test;
    i. Summary finding;
    j. Recommendations, including prescription of corrective lenses.
2. A second vision exam within 60 days of an optometrist's exam, when an optometrist suspects a problem and refers a Member to an ophthalmologist.
3. Prescribed frames and lenses or contact lenses including directly related Health Care Provider services such as:
    a. Measurement of face and interpupillary distance;
    b. Quality assurance;
    c. Reasonable aftercare to fit, adjust, and maintain comfort and effectiveness;
    d. Help in choosing frames.
4. For adult Members: One pair of frames per Benefit Period.
5. For pediatric Members: One pair of frames per Benefit Period.
6. For adult Members: One pair of prescription lenses per Benefit Period:
    a. Single or multi vision;
    b. Tinted no darker than Tint #2.

7. For pediatric Members: One pair of prescription lenses per Benefit Period:

   a. Single or multi vision;

   b. Tinted no darker than Tint #2.

8. One pair of prescription contact lenses, or multiple pairs of prescription contact lenses if the Member selects disposable contact lenses except as stated below:

   a. When Medically Necessary as a result of cataract surgery; or when visual acuity of at least 20/70 in the better eye can be obtained only by use of contact lenses.

   b. At the election of the Member (in place of frames and lenses).

SECTION C EXCLUSIONS

Note: These exclusions are in addition to the exclusions in the Exclusions section of the Evidence of Coverage.

Benefits are not provided for:

1. Diagnostic services, except as may be necessary for a vision exam.

2. Medical care or surgery.

3. Prescription Drugs, except as may be necessary for a vision exam.

4. Orthoptics, vision training, and low vision aids.

5. Except as otherwise provided, vision care services for Cosmetic use.

6. Replacement, within the same Benefit Period, of frames, lenses or contact lenses that were lost or broken.

7. Non-prescription glasses, sunglasses or contact lenses.

8. Sunglasses.

SECTION D EXTENSION OF BENEFITS

During an extension period under this Evidence of Coverage, premium may not be charged.

Benefits will cease as of 11:59 p.m., Eastern Standard Time, on the Subscriber's termination date.

If a Member has ordered lenses and frames or contact lenses before the date coverage terminates, CareFirst will provide coverage for the lenses and frames or contact lenses if received within 30 days after the date of the order.

This extension of benefits will not apply if:

1. Coverage is terminated for non-payment of the required premium by the Member; or

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

3. The member obtained uninterrupted and comparable coverage under a succeeding vision plan that is less than the cost to the Member of the extended benefit.

SECTION E SCHEDULE OF BENEFITS

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

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

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

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

ADULT VISION CARE BENEFITS		
Covered Service	**CareFirst Payment***	
	Participating provider	**Non-Participating Provider**
Vision Exam	**Limitations** Benefits are available to Members nineteen (19) years old and older. Benefits are limited to one (1) vision exam per Benefit Period.	
	No Deductible required 100% of Routine Vision Allowed Benefit	80% of Routine Vision Allowed Benefit**

*The Member is responsible for the difference between CareFirst's payment and the Health Care Provider's charge.
**Non-Participating Provider Covered Services are subject to the out-of-network Deductible set forth in the Schedule Of Benefits for the medical portion of the Evidence of Coverage.

ADULT VISION CARE BENEFITS		
Covered Service	**CareFirst Payment***	
	Participating Provider	**Non-Participating Provider**
Frames, Lenses and Contact Lenses	**Limitations** Benefits are available to Members nineteen (19) years old and older.	
Frames	No Deductible required 100% of Routine Vision Allowed Benefit up to $45.00 per frame	80% of Routine Vision Allowed Benefit up to $45.00 per frame**
Lenses		
Covered Basic lenses are spectacle lenses (excluding specialty lenses with glare resistant treatment, ultraviolet coating, progressive lenses and transitional lenses and other special treatments).		
Basic Single vision	No Deductible required 100% of Routine Vision Allowed Benefit up to $52.00	80% of Routine Vision Allowed Benefit**
Basic Bifocal	No Deductible required 100% of Routine Vision Allowed Benefit up to $82.00	80% of Routine Vision Allowed Benefit**
Basic Trifocal	No Deductible required 100% of Routine Vision Allowed Benefit up to $101.00	80% of Routine Vision Allowed Benefit**
Basic Lenticular	No Deductible required 100% of Routine Vision Allowed Benefit up to $181.00	80% of Routine Vision Allowed Benefit**
Contact Lenses The Routine Vision Allowed Benefit for contact lenses is the actual charge.		
Medically Necessary	No Deductible required 100% of Routine Vision Allowed Benefit up to $285.00	80% of Routine Vision Allowed Benefit**
Elective contact lenses (in place of frames and lenses)	No Deductible required 100% of Routine Vision Allowed Benefit Unlimited up to $97.00	80% of Routine Vision Allowed Benefit**

*The Member is responsible for the difference between CareFirst's payment and the Health Care Provider's charge.

PEDIATRIC VISION CARE BENEFITS		
Covered Service	**CareFirst Payment***	
	Participating provider	**Non-Participating Provider**
Vision Exam	**Limitations** Benefits are available to pediatric Members eighteen (18) years old and younger.	
	No Deductible required 100% of Routine Vision Allowed Benefit	80% of Routine Vision Allowed Benefit**

*The Member is responsible for the difference between CareFirst's payment and the Health Care Provider's charge.
**Non-Participating Provider Covered Services are subject to the out-of-network Deductible set forth in the Schedule Of Benefits for the medical portion of the Evidence of Coverage.

PEDIATRIC VISION CARE BENEFITS		
Covered Service	**CareFirst Payment***	
	Participating provider	**Non-Participating Provider**
	Limitations Benefits are available to pediatric Members eighteen (18) years old and younger.	
Frames	No Deductible required 100% of Routine Vision Allowed Benefit up to $70.00 per frame	80% of Routine Vision Allowed Benefit
Lenses		
Covered Basic lenses are spectacle lenses (excluding specialty lenses with glare resistant treatment, ultraviolet coating, progressive lenses and transitional lenses and other special treatments). The Member may choose either traditional frames/lenses benefits or contact lenses per Benefit Period. **The Routine Vision Allowed Benefit for lenses and contact lenses is the actual charge.		
Basic Single vision	No Deductible required 100% of Routine Vision Allowed Benefit**	80% of Routine Vision Allowed Benefit**
Basic Bifocal		
Basic Trifocal		
Basic Lenticular		
Contact Lenses	**Limitations** Benefits for disposable contact lenses are limited to two (2) refills per Benefit Period.	
Medically Necessary	No Deductible required 100% of Routine Vision Allowed Benefit**	80% of Routine Vision Allowed Benefit**
Elective contact lenses (in place of frames and lenses)		

*The Member is responsible for the difference between CareFirst's payment and the Health Care Provider's charge.

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

ELIGIBILITY SCHEDULE FOR MEDICARE OPTION

ELIGIBILITY		
The following persons meeting the eligibility requirements established by the Group are eligible for Preferred Provider Organization with Medicare Option benefits and Vision Care benefits under this Evidence of Coverage:		
Subscriber	A retiree under the terms of the Group's retirement program, as amended from time to time and the retiree's Dependents. An employee enrolled in Medicare as a result of End Stage Renal Disease (ESRD).	
Dependent Spouse	Coverage for a Medicare-eligible Dependent Spouse, is available.	
Domestic Partner	Coverage for a Domestic Partner is available. Domestic Partner coverage includes coverage for Medicare-eligible Domestic Partners.	
Dependent children	Coverage for Medicare-eligible Dependent children, including children of a Domestic Partner, is available.	**Limiting Age** Up to age 26
Unmarried incapacitated Dependent children	A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if: 1. The Dependent child is permanently disabled; 2. The Dependent child is unable to be self-supporting due to a mental or physical handicap or disability; 3. The Dependent child is primarily dependent on the Subscriber for support; 4. The Subscriber provides to the Group (or CareFirst if the Group so elects) proof of the Dependent child's permanent disability within sixty (60) days of the date coverage would have otherwise ended because the child reached a certain age. Once a certification of permanent disability is accepted by the Group, the accepted certification is valid for the duration of the Dependent child's lifetime; 5. Upon the Group's request, the Subscriber provides proof of the Dependent child's continued disability; and 6. The onset of disability must have occurred before the child reached age 26. Proof of permanent disability may require medical examinations provided at the Group's expense. Proof will not be required more than once a year. If proof of disability is not provided within sixty (60) days, benefits will not be available for the Dependent child under this Evidence of Coverage. If all the requirements above are met, coverage for the Dependent child under this Evidence of Coverage will continue as long as the Dependent child is incapacitated and dependent on the Subscriber, unless coverage is otherwise terminated in accordance with the terms of the Plan. Proof of disability is not required until the Dependent child reaches age 26.	**Limiting Age** Not applicable

EFFECTIVE DATES	
Open Enrollment	The Group's Contract Date
Newly eligible Subscriber and Dependents	The date determined by the Group.

TERMINATION OF COVERAGE	
Subscriber no longer eligible	A Subscriber will remain covered until the end of the month.
Dependents	A Dependent will remain covered until the end of the month.
Nonpayment by the Group	Coverage will terminate on the date stated in CareFirst's written notice of termination.
Fraud or intentional misrepresentation of material fact	Coverage will terminate on the date stated in CareFirst's and/or the Group's written notice of termination.

SCHEDULE OF BENEFITS FOR MEDICARE OPTION

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

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

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

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

A Member entitled to Medicare as his or her primary coverage, whether or not the Member has applied for, claimed, or received Medicare benefits is eligible.

Covered services are stated in Preferred Medicare Option:

1. CareFirst will pay only those benefits which exceed the benefits available under Medicare, regardless of whether the Member has actually applied for, claimed or received Medicare benefits.

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

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

CareFirst will not provide a benefit for:

1. Expenses which would have been paid under Medicare, had the Member applied for or claimed such benefits;

2. Expenses excluded from coverage under Medicare except as stated in Preferred Medicare Option.

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

DEDUCTIBLE: Out-of-Network Only	
Individual	**Family**
$250	$500
Deductible applicable to out-of-network Covered Services, except as stated in the Schedule of Benefits.	
The Deductible is calculated based on the Allowed Benefit of Covered Services.	
When the Type of Coverage is Individual, CareFirst will pay for all or part of remaining Covered Services when the Member reaches the Individual Deductible amount. When the Type of Coverage is Family, the Family Deductible amount is calculated by combining the amounts contributed by all the family Members covered under the Family Type of Coverage. CareFirst pays benefits for a family Member in a Family Type of Coverage who reaches the Individual Deductible amount before the Family Deductible amount is reached. A family Member may not contribute more than the Individual Deductible amount to the Family Deductible amount.	
The following amounts apply to the Deductible:	The following amounts may not be used to satisfy the Deductible:
- 100% of the Allowed Benefit for Covered Services that are subject to the Deductible.	- Charges in excess of the Allowed Benefit. - Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days listed below. - Charges for Covered Services not subject to the Deductible.

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

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

OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM		
	Individual	Family
Deductible	$250	$500
Plan Year Out-of- Pocket Coinsurance and Deductible Combined Maximum	$3,000	$6,000
Total Medical Out-of-Pocket Maximum	$3,000	$6,000

The family Out-of-Pocket Maximums are calculated in the aggregate.

A family Member may **not** contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.

CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Out-of-Pocket Maximum is met. Copays will be waived for the remainder of the Benefit Period.

Coinsurance Out-of-Pocket Maximum

1. CareFirst's payment for Covered Services will increase to 100% of the Allowed Benefit for the remainder of the Benefit Period when the Coinsurance Out-of-Pocket Maximum is met.

2. The following amounts contribute to the Coinsurance Out-of-Pocket Maximum:
   - Deductible (Out-of-Network)
   - Coinsurance (Member's share)

All cost-share payments made by the Member for the following Covered Services will contribute towards the in-network Out-of-Pocket Maximum:

- Emergency Services provided by Non-Preferred Health Care Providers.

- Air Ambulance Services provided by Non-Preferred Health Care Providers.

- Non-emergency Covered Services provided by Non-Preferred Health Care Providers at Preferred Health Care facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Non-Preferred Health Care Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in the "How the Plan Works" of this Evidence of Coverage.

Covered Services provided by a Preferred Health Care Provider, when the Member relied on a database, provider directory, or information provided by CareFirst regarding the Health Care Provider's status (through a telephone call or electronic means) which incorrectly indicated that the Health Care Provider was a Preferred Health Care Provider for the Covered Service received.

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

IMPORTANT NOTE REGARDING MEMBER'S COST-SHARE AND PAYMENT FOR CERTAIN COVERED SERVICES PROVIDED BY NON-PREFERRED HEALTH CARE PROVIDERS

Any Copayment, Coinsurance, and/or other cost-sharing requirement for services provided by Non-Preferred Health Care Providers **will be the same** as the Copayment, Coinsurance, and/or other cost-sharing requirement stated in this Schedule of Benefits for services provided by Preferred Health Care Providers, for the following Covered Services:

- Emergency Services provided by Non-Preferred Health Care Providers.
- Air ambulance services provided by Non-Preferred Health Care Providers.
- Non-emergency Covered Services provided by Non-Preferred Health Care Providers at Preferred Health Care facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Non-Preferred Health Care Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in the "How the Plan Works" of this Evidence of Coverage.
- Covered Services provided by a Preferred Health Care Provider, when the Member relied on a database, provider directory, or information provided by CareFirst regarding the Health Care Provider's status (through a telephone call or electronic means) which incorrectly indicated that the Health Care Provider was a Preferred Health Care Provider for the Covered Service received.

IMPORTANT NOTE REGARDING INTERNATIONAL OUTPATIENT PROFESSIONAL AND FACILITY SERVICES

The Allowed Benefit for outpatient professional practitioner services and facility services provided internationally will be the international provider's actual charge and benefits are available to the same extent as benefits provided for outpatient professional and outpatient facility services provided by Preferred Providers.

Covered Services	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Infant, child, and adolescent preventive and wellness services	**Limitations** Benefits for child preventive and routine care are limited to thirteen (13) visits for Members age newborn through thirty-six (36) months; thereafter, and one (1) visit per Benefit Period.	
Office visit		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Immunizations		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Diagnostic services		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	Hospital, Outpatient Professional, or Office 80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit

Covered Services	CareFirst Payment	
	In-Network	**Out-of-Network**
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Adult preventive and wellness services	**Limitations** Benefits for adult preventive care are limited to one (1) visit per Benefit Period. Benefits for counseling for sexually transmitted infections are available for Members and limited to one (1) visit per Benefit Period. Benefits for counseling and screening for interpersonal and domestic violence are available for Members and are limited to one (1) visit per Benefit Period.	
Office visits		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Immunizations		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Diagnostic services		
When Medicare pays	Hospital, Outpatient Professional, or Office 100% of Medicare Part B deductible and/or coinsurance	Hospital, Outpatient Professional, or Office 80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	Hospital, Outpatient Professional, or Office 100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit
Chlamydia screening		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	Hospital, Outpatient Professional, or Office 80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit

Covered Services	CareFirst Payment	
	In-Network	**Out-of-Network**
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Colorectal cancer screening (including colonoscopy, flexible sigmoidoscopy)		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	Hospital, Outpatient Professional, or Office 80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit
Hepatitis C screening		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	Hospital, Outpatient Professional, or Office 80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit
Human papillomavirus screening	Limitations Benefits for Human Papillomavirus testing are limited to one (1) screening every three (3) years for Members thirty (30) years old and older.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	Hospital, Outpatient Professional, or Office 80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit
Breast cancer screening	Limitations Benefits for mammography screening are limited to one (1) screening every Benefit Period for Members thirty-five (35) years old and older.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	Hospital, Outpatient Professional, or Office 80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit

Covered Services	CareFirst Payment	
	In-Network	**Out-of-Network**
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services		
Osteoporosis prevention		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	Hospital, Outpatient Professional, or Office 80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit
Prostate cancer screening		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	Hospital, Outpatient Professional, or Office 80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	Hospital, Outpatient Professional, or Office 80% of Allowed Benefit
Flu Shots	100% of Allowed Benefit	No benefit
Subsequent treatment of a condition diagnosed during a preventive and wellness services office visit (treatment for which is not included in preventive and wellness services benefits)	Benefits are available to the same extent as benefits provided for other illnesses.	
Primary purpose of the office visit is not the delivery of preventive and wellness services		
Office visit and, if not billed separately, preventive and wellness services	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Ambulance Services (Emergency and Non-Emergency)	**Limitations** Ambulance services (ground, surface, air, and sea) are limited, as follows: • Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance.	
Emergency Ambulance Services		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	No Deductible required 100% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Non-Emergency Ambulance Services		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Applied Behavior Analysis services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Complex Chronic or High Risk Acute Disease Management	**Limitations** Home Health Care hospital/home health agency visit limit does not apply to Home-Based Services Program (HBS). Benefits will be provided as described in the Description of Covered Services for Complex Chronic or High Risk Acute Disease Management or Patient-Centered Medical Home Program.	
Services provided pursuant to a plan of care	100% of Allowed Benefit	No benefit
TCCI Program elements		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Controlled Clinical Trials Patient Costs	**Limitations** Hospital Pre-Certification and Review is required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Diabetes-Related Services		
Diabetes equipment, supplies, and self-management training		
When Medicare pays	Benefits are available to the same extent as benefits provided for Medical Supplies and outpatient medical care	
When Medicare does not pay		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Emergency Services and Urgent Care		
Emergency Services in a hospital emergency room/department**		
Hospital emergency room/ department and Ancillary Services routinely available to the emergency room/department to evaluate an Emergency Medical Condition		
Outpatient professional practitioner(s) in hospital emergency room/department		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	No Deductible required 100% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Member admitted as inpatient	Benefits are available to the same extent as benefits provided for other In-Network inpatient services.	
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department		
Office (except diagnostic or surgical services performed in an office)		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Diagnostic or surgical services performed in an office		
When Medicare pays	Benefits are available to the same extent as benefits provided for non-preventive outpatient diagnostic services.	
When Medicare does not pay		
Urgent Care center		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Dental services related to accidental injury or trauma		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	No Deductible required 100% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit

**To determine the CareFirst Payment for Covered Services provided outpatient professional practitioner Covered Services in an emergency room/department, the claim will be suspended for five (5) days from the date of receipt until the corresponding facility claim is received. Once the facility claim is received, the outpatient professional practitioner claim will be paid as Emergency Services if the facility claim was for Emergency Services; the outpatient professional practitioner claim will be paid as illness medical care and consultation (i.e., non-Emergency Services) if the facility claim was for non-Emergency Services. If no corresponding facility claim is submitted, the CareFirst Payment for outpatient professional practitioner Covered Services will be determined solely on the outpatient professional practitioner claim.
Note: Benefits for HIV testing performed in a hospital emergency room are not subject to the Deductible.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Expert Consultation Program	100% of Allowed Benefit	No benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Gender Dysphoria Services	**Limitations** Hospital PreCertification & Review is required for inpatient services. Pre-authorization is required for outpatient services. Benefits for gender dysphoria services are limited to the extent provided in the Description of Covered Services.	
Outpatient psychotherapy/mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses	Benefits are available to the same extent as benefits provided for other inpatient Covered Services, outpatient Covered Services, and Prescription Drug Covered Services.	
Continuous hormone replacement therapy		
Outpatient laboratory testing to monitor continuous hormone therapy		
Gender reassignment surgery		
Augmentation mammoplasty (including breast prosthesis if necessary)		
Post gender reassignment benefits		

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

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Home Health Care	**Limitations** An approved Plan of Treatment is required for Home Health Care. Hospital/home health agency: One-hundred and twenty (120) days of unlimited Home Health Care Visits per Benefit Period. Home health aid: Forty (40) Home Health Care Visits per Benefit Period.	
Hospital/home health agency		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Home visits following childbirth	Home Health Care Visit limits, if any, do not apply.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Home visits following mastectomy	Home Health Care Visit limits, if any, do not apply.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Home visits following the surgical removal of a testicle	Home Health Care Visit limits, if any, do not apply.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Hospice care (including facility/agency services, Respite care, bereavement counseling, and family counseling)	**Limitations** An approved Plan of Treatment is required for hospice care; the Plan of Treatment must be accepted in writing by the Member and/or family. There must be a willing and able Caregiver available. Respite Care is limited to a maximum of fourteen (14) days per Benefit Period. At the discretion of CareFirst, Respite Care may be limited to five (5) consecutive days for each inpatient stay. Bereavement counseling is limited to the six (6) month period following the Member's death or fifteen (15) visits, whichever occurs first.	
When Medicare pays	100% of Medicare Part A/B deductible and/or coinsurance	80% of Medicare Part A/B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Infertility services		
Artificial insemination (AI)/ intrauterine insemination (IUI)	**Limitations** Prior authorization is required. Benefits for artificial insemination (AI) and/or intrauterine insemination (IUI) are limited to six (6) attempts per live birth.	
Hospital		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Office		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
In vitro fertilization (IVF)	**Limitations** Prior authorization is required. Benefits for in vitro fertilization (IVF) are limited to three (3) attempts per live birth.	
Hospital		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Office		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Fertility Prescription Drugs for artificial insemination/intrauterine insemination and in vitro fertilization	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Inpatient Health Care Provider Services	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Inpatient hospital or health care facility	**Limitations** Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
Day 1 through 60		
When Medicare pays	100% of Medicare Part A deductible and coinsurance	80% of Medicare Part A deductible and coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Day 61 through 90		
When Medicare pays	100% of Medicare Part A deductible and coinsurance	80% of Medicare Part A deductible and coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Lifetime Reserve Days(60-days)	100% of Medicare coinsurance days	80% of Medicare coinsurance days
Skilled Nursing Facility	**Limitations** Hospital Pre-Certification and Review is required. Skilled Nursing Facility services are limited to 180 days per Benefit Period. Medicare pays for the first 20 days.	
When Medicare pays: (Day 1 through 20)	100% of Medicare Part A deductible and coinsurance	80% of Medicare Part A deductible and coinsurance
When Medicare does not pay: (Day 21 through 180)	100% of Allowed Benefit	80% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery (including radiologists*, pathologists, anesthesiologists*, and surgical assistants)**		
When Medicare pays	100% of Medicare Part A deductible and coinsurance	80% of Medicare Part A deductible and coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

*If the anesthesiologist is Non-Contracting, the claim will be suspended until the facility claim is received not to exceed 30 days. If the facility is Contracting upon receipt of claim, the anesthesiology claim will be paid in-network (100% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 100%). If the facility is Non-Contracting upon receipt of claim, the anesthesiology claim will be paid out-of-network (80% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 80%). If the facility claim is not received within 30 days, the claim will default to the out-of-network benefit (80% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 80%).

If the radiologist is Non-Contracting, the claim will be suspended until the facility claim is received not to exceed 30 days. If the facility is Contracting upon receipt of claim, radiology claim will be paid in-network (100% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 100%). If the facility is Non-Contracting upon receipt of claim, radiology claim will be paid out-of-network (80% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 80%). If the facility claim is not received within 30 days, the claim will default to the out-of-network benefit (80% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 80%).

**When Covered Services are billed by the health care practitioner (instead of the Hospital/facility or Skilled Nursing Facility) CareFirst payment will be as follows: 90/70% Medicare Part B deductible and coinsurance.

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Inpatient/Outpatient Health Care Provider Services		
Contraceptive exam, insertion and removal		
When Medicare pays	100% of Medicare Part B deductible and coinsurance	No benefit
When Medicare does not pay	100% of Allowed Benefit	
Cleft lip or cleft palate, or both		
Orthodontics, oral surgery		
When Medicare pays	100% of Medicare Part B deductible and coinsurance	80% of Medicare Part B deductible and coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Otological, audiological and speech/language treatment	Rehabilitative Services visit limits for Speech Therapy, if any, do not apply.	
When Medicare pays	100% of Medicare Part B deductible and coinsurance	80% of Medicare Part B deductible and coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Family planning services		
Contraceptive counseling (except for fertility awareness-based methods)		
When Medicare pays	100% of Medicare Part B deductible and coinsurance	No benefit
When Medicare does not pay	100% of Allowed Benefit	No benefit
Fertility Awareness-Based Methods contraceptive counseling		
When Medicare pays	100% of Medicare Part B deductible and coinsurance	No Deductible required 100% of Medicare Part B deductible and coinsurance
When Medicare does not pay	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Treatment of flat foot conditions	Limitations Benefits are limited to the evaluation and Medically Necessary management services only.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Mastectomy-related services	Benefits are available to the same extent as benefits provided for other illnesses.	
Home visits following mastectomy	Home Health Care Visit limits, if any, do not apply.	
	See Home Health Care	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Maternity services and newborn care	**Limitations** Benefits for gestational diabetes screening are available between 24-28 weeks gestation.	
Maternity services and newborn care except preventive prenatal services	Benefits are available to the same extent as benefits provided for other illnesses.	
Preventive Prenatal Services		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Lactation support and counseling		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	No Benefit
When Medicare does not pay	100% of Allowed Benefit	No Benefit
Breastfeeding supplies and equipment	**Limitations** Benefits for breast pumps and supplies directly related to the operation of breast pumps are only covered when provided by In-Network Durable Medical Equipment providers. The breast pumps and supplies directly related to the operation of breast pumps are not covered Out-of-Network. All other breastfeeding supplies are not covered.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	No Benefit
When Medicare does not pay	100% of Allowed Benefit	No Benefit
Circumcision by a Mohel		
When Medicare pays	No benefit	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay		80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Medical Devices and Supplies		
Durable Medical Equipment		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Hair prosthesis	**Limitation** Benefits are limited to one (1) hair prosthesis per Benefit Period.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Hearing Aids	Benefits are available as stated in the Hearing Care Rider.	
Non-routine services related to the Hearing Aid dispensing	Benefits are available to the same extent as benefits provided for other illnesses.	
Medical foods and nutritional substances		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Medical Supplies		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Orthotic Devices, Prosthetic Devices (except leg, arm, and eye)		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Orthotic Devices; Prosthetic Devices, leg, arm, eye		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

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

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Mental health and substance use disorder services, including behavioral health treatment	Subject to the requirements of PPACA, the CareFirst payment for Members receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission	
Telemedicine Services for mental health and substance use disorder services, including behavioral health treatment		
Video visits provided by Designated Virtual Care Provider	Benefits are available to the same extent as benefits for face-to-face outpatient mental health and substance use disorder services office visits, stated above.	No benefit
Telephonic consultations (audio-only)	Benefits are available to the same extent as benefits for face-to-face outpatient mental health and substance use disorder services office visits, stated above.	
Other Telemedicine Services	Benefits are available to the same extent as benefits for face-to-face outpatient mental health and substance use disorder services office visits, stated above.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Non-Preventive Outpatient Diagnostic Services (includes pre-admission testing)		
Laboratory tests and X-Rays		
Hospital		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner*		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Office		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient Non-Preventive Diagnostic Breast Examinations and Supplemental Breast Examinations		
Outpatient department of a hospital	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Independent/Freestanding facility		
Outpatient professional practitioner		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Follow-up diagnostic imaging of the Lungs (including diagnostic image-guided biopsy of the lungs for cancer)		
Outpatient department of a hospital	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Independent/Freestanding facility		
Outpatient professional practitioner		

*If the radiologist is Non-Contracting, the claim will be suspended until the facility claim is received not to exceed 30 days. If the facility is Contracting upon receipt of claim, radiology claim will be paid in-network (100% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 100%). If the facility is Non-Contracting upon receipt of claim, radiology claim will be paid out-of-network (80% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 80%). If the facility claim is not received within 30 days, the claim will default to the out-of-network benefit (80% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 80%).

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Observation Services		
Observation room via the emergency room within one (1) day		
When Medicare pays	100% of Medicare Part B deductible and coinsurance	No Deductible required 100% of Medicare Part B deductible and coinsurance
When Medicare does not pay	100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Observation room by way of and including the emergency room services of greater than one (1) day or more		
When Medicare pays	100% of Medicare Part B deductible and coinsurance	80% of Medicare Part B deductible and coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Organ and tissue transplants	**Limitations** Benefits are limited to the extent stated in the Organ and Tissue Transplant subsection of the Description of Covered Services. Organ transplant travel benefits are limited to sixty (60) days per transplant. Travel benefits are limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. Pre-authorization is required for outpatient bone marrow transplants.	
Organ and tissue transplants	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant procurement		
Organ transplant travel	100% of Allowed Benefit*	No Deductible required 100% of Allowed Benefit*

*The Allowed Benefit is the actual charge.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Medical care and consultations (illness visits)		
Outpatient hospital/facility		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Office		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Retail Health Clinic		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Urgent Care center		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Illness visit to a hospital emergency room/department (**not** Emergency Services)		
When Medicare pays	50% of Medicare Part B deductible and/or coinsurance	No Deductible required 50% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	50% of Allowed Benefit	No Deductible required 50% of Allowed Benefit
Telemedicine Services		
Video visits provided by Designated Virtual Care Provider	100% of Allowed Benefit	80% of Allowed Benefit
Telephonic consultations (audio-only)	100% of Allowed Benefit	80% of Allowed Benefit
Other Telemedicine Services	100% of Allowed Benefit	80% of Allowed Benefit
Routine outpatient hospital visits/clinic/other hospital services		
When Medicare pays	100% of Medicare Part B deductible and coinsurance	80% of Medicare Part B deductible and coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Outpatient Surgical Services		
Surgery		
Outpatient hospital/facility		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Outpatient professional practitioner		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Office		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Ambulatory surgical facility services		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Anesthesiologist* and surgical assistant		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Female elective sterilization		
When Medicare pays	100% of Medicare Part B deductible and coinsurance	No benefit
When Medicare does not pay	100% of Allowed Benefit	
Male elective sterilization		
When Medicare pays	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	
When Medicare does not pay		

*If the anesthesiologist is Non-Contracting, the claim will be suspended until the facility claim is received not to exceed 30 days. If the facility is Contracting upon receipt of claim, the anesthesiology claim will be paid in-network (100% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 100%). If the facility is Non-Contracting upon receipt of claim, the anesthesiology claim will be paid out-of-network (80% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 80%). If the facility claim is not received within 30 days, the claim will default to the out-of-network benefit (80% of Medicare Part B deductible and/or coinsurance when Medicare pays, otherwise 80%).

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Acupuncture for chronic pain management		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Administration of injectable Prescription Drugs		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Allergen immunotherapy (allergy injections) including the allergenic extracts (sera)		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Allergy testing		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Chemotherapy		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Home Infusion Therapy		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Inhalation therapy		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Radiation therapy		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Renal dialysis		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Health Care Provider Services		
Spinal manipulation/chiropractic services		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Vision therapy (orthoptics/pleoptics)		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Private Duty Nursing	**Limitations** An approved Plan of Treatment is required. No inpatient Private Duty Nursing benefits are available.	
Facility/agency	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Prescription Drugs	**Limitations** Benefits are not available through CareFirst for Pharmacy-dispensed Prescription Drugs. Benefits available through CareFirst for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.	
Prescription Drugs	Benefits are available to the same extent as benefits provided for other illnesses.	
Injectable Prescription Drugs that require administration by a Health Care Provider, except: • allergenic extracts (allergy sera) • Prescription Drug contraceptives and contraceptive devices	Benefits are available to the same extent as benefits provided for other illnesses.	
Prescription Drug contraceptives and contraceptive devices dispensed in the office of a Health Care Provider		
When Medicare pays	100% of Medicare Part B deductible and coinsurance	No benefit
When Medicare does not pay	100% of Allowed Benefit	

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

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Professional Nutritional Counseling/Medical Nutrition Therapy (non-routine)		
All outpatient places of service		
When Medicare pays	100% of Medicare Part B deductible and coinsurance	80% of Medicare Part B deductible and coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Rehabilitative and Habilitative Services		
Inpatient Rehabilitative Services	**Limitations** Inpatient Rehabilitative Services are covered when Medically Necessary. Hospital Pre-Certification and Review is required.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	No benefit
When Medicare does not pay	100% of Allowed Benefit	
Outpatient Rehabilitative Services	**Limitations** Benefits are limited to fifty (50) combined visits per Benefit Period for: • Occupational Therapy • Physical Therapy • Speech Therapy. A Plan of Treatment is required for Speech Therapy after the first (1st) visit. A Plan of Treatment is required for Physical Therapy after the twentieth (20th) visit per Benefit Period. A Plan of Treatment is required for Occupational Therapy after the twentieth (20th) visit per Benefit Period.	
Occupational Therapy	Visit limit, if any, does not apply to Habilitative Services Covered Services.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Physical Therapy*	Visit limit, if any, does not apply to Habilitative Services Covered Services. *Physical Therapy provided by an acupuncturist will be available to same extent as Acupuncture services.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Speech Therapy	Visit limit, if any, does not apply to Habilitative Services Covered Services.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Cardiac Rehabilitation	**Limitations** An approved Plan of Treatment is required. Benefits are limited to a maximum of 36 sessions within a 12 week period per medical event with physician supervision. A physician referral is required.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative and Habilitative Services		
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Habilitative Services	**Limitations** An approved Plan of Treatment is required for Habilitative Services. Benefits are available for Members until the end of the month in which the Member turns nineteen (19) years old. Outpatient rehabilitative services visit limits, if any, do not apply to Habilitative Services Covered Services.	
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit
Pulmonary Rehabilitation		
When Medicare pays	100% of Medicare Part B deductible and/or coinsurance	80% of Medicare Part B deductible and/or coinsurance
When Medicare does not pay	100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Surgical treatment of Morbid Obesity	**Limitations** Benefits are limited to the extent stated in the Description of Covered Services. Pre-authorization is required for outpatient morbid obesity surgery.	
	Benefits are available to the same extent as surgical benefits provided for other illnesses.	

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HEARING CARE RIDER FOR MEDICARE OPTION

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

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

Benefits are available for:

1. Screening examination to diagnose hearing loss.

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

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

4. Hearing aids if:

    a. Basic standard model (behind the ear model);

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

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

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

Benefits are not provided for:

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

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

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

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

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Hearing care	**Limitations** Benefits are limited to once per 3 years.	
Hearing aid evaluation tests	100% of Allowed Benefit	80% of Allowed Benefit
Hearing aids (basic model for monaural/binaural)	100% of Allowed Benefit up to $5,000	80% of Allowed Benefit
Hearing exam/Audiometric tests	100% of Allowed Benefit	80% of Allowed Benefit
Hearing aid repair		
For Members who are minor children	100% of Allowed Benefit	100% of Allowed Benefit
For adult Members	100% of Allowed Benefit	80% of Allowed Benefit

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VISION CARE BENEFITS RIDER FOR MEDICARE OPTION

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

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SECTION A DEFINITIONS

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

Routine Vision Allowed Benefit means:

1. For a Participating Provider, the Routine Vision Allowed Benefit for a Covered Service is the lesser of:

   a. The actual charge; or

   b. The amount the Group CareFirst allows for the service in effect on the date that the service is rendered.

   The benefit is payable to the Participating Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.

2. For a Non-Participating Provider, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit payable to a Participating Provider. The benefit is payable to the Subscriber, or to the Non-Participating Provider, at the discretion of CareFirst. The Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the Non-Participating Provider's actual charge. It is the Member's responsibility to apply any CareFirst payments to the Non-Participating Provider's charges.

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

Non-Participating or Non-Par Provider means any Health Care Provider that does not contract with CareFirst.

Participating Provider or Par Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members.

SECTION B DESCRIPTION OF COVERED SERVICES

Benefits are available for:

1. A vision exam which may include:
    a. Case history;
    b. External exam of eye and adnexa;
    c. Ophthalmoscopic exams;
    d. Determination of refractive status;
    e. Binocular balance test;
    f. Tonometry test for glaucoma;
    g. Gross visual fields;
    h. Color vision test;
    i. Summary finding;
    j. Recommendations, including prescription of corrective lenses.
2. A second vision exam within 60 days of an optometrist's exam, when an optometrist suspects a problem and refers a Member to an ophthalmologist.
3. Prescribed frames and lenses or contact lenses including directly related Health Care Provider services such as:
    a. Measurement of face and interpupillary distance;
    b. Quality assurance;
    c. Reasonable aftercare to fit, adjust, and maintain comfort and effectiveness;
    d. Help in choosing frames.
4. For adult Members: One pair of frames per Benefit Period.
5. For pediatric Members: One pair of frames per Benefit Period.
6. For adult Members: One pair of prescription lenses per Benefit Period:
    a. Single or multi vision;
    b. Tinted no darker than Tint #2.

7. For pediatric Members: One pair of prescription lenses per Benefit Period:

   a. Single or multi vision;

   b. Tinted no darker than Tint #2

8. One pair of prescription contact lenses, or multiple pairs of prescription contact lenses if the Member selects disposable contact lenses except as stated below:

   a. When Medically Necessary as a result of cataract surgery; or when visual acuity of at least 20/70 in the better eye can be obtained only by use of contact lenses.

   c. At the election of the Member (in place of frames and lenses).

SECTION C EXCLUSIONS

Note: These exclusions are in addition to the exclusions in the Exclusions section of the Evidence of Coverage.

Benefits are not provided for:

1. Diagnostic services, except as may be necessary for a vision exam.

2. Medical care or surgery.

3. Prescription Drugs, except as may be necessary for a vision exam.

4. Orthoptics, vision training, and low vision aids.

5. Except as otherwise provided, vision care services for Cosmetic use.

6. Replacement, within the same Benefit Period, of frames, lenses or contact lenses that were lost or broken.

7. Non-prescription glasses, sunglasses or contact lenses.

8. Sunglasses.

SECTION D EXTENSION OF BENEFITS

During an extension period under this Evidence of Coverage, premium may not be charged.

Benefits will cease as of 11:59 p.m., Eastern Standard Time, on the Subscriber's termination date.

If a Member has ordered lenses and frames or contact lenses before the date coverage terminates, CareFirst will provide coverage for the lenses and frames or contact lenses if received within 30 days after the date of the order.

This extension of benefits will not apply if:

1. Coverage is terminated for non-payment of the required premium by the Member; or

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

3. The member obtained uninterrupted and comparable coverage under a succeeding vision plan that is less than the cost to the Member of the extended benefit.

SECTION E SCHEDULE OF BENEFITS

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

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

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

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

ADULT VISION CARE BENEFITS		
Covered Service	**CareFirst Payment***	
	Participating provider	**Non-Participating Provider**
Vision Exam	**Limitations** Benefits are available to Members nineteen (19) years old and older. Benefits are limited to one (1) vision exam per Benefit Period.	
	No Deductible required 100% of Routine Vision Allowed Benefit	80% of Routine Vision Allowed Benefit**

*The Member is responsible for the difference between CareFirst's payment and the Health Care Provider's charge.
**Non-Participating Provider Covered Services are subject to the out-of-network Deductible set forth in the Schedule Of Benefits for the medical portion of the Evidence of Coverage.

ADULT VISION CARE BENEFITS		
Covered Service	**CareFirst Payment***	
	Participating Provider	**Non-Participating Provider**
Frames, Lenses and Contact Lenses	**Limitations** Benefits are available to Members nineteen (19) years old and older.	
Frames	No Deductible required 100% of Routine Vision Allowed Benefit up to $45.00 per frame	80% of Routine Vision Allowed Benefit up to $45.00 per frame**
Lenses		
Covered Basic lenses are spectacle lenses (excluding specialty lenses with glare resistant treatment, ultraviolet coating, progressive lenses and transitional lenses and other special treatments).		
Basic Single vision	No Deductible required 100% of Routine Vision Allowed Benefit up to $52.00	80% of Routine Vision Allowed Benefit**
Basic Bifocal	No Deductible required 100% of Routine Vision Allowed Benefit up to $82.00	80% of Routine Vision Allowed Benefit**
Basic Trifocal	No Deductible required 100% of Routine Vision Allowed Benefit up to $101.00	80% of Routine Vision Allowed Benefit**
Basic Lenticular	No Deductible required 100% of Routine Vision Allowed Benefit up to $181.00	80% of Routine Vision Allowed Benefit**
Contact Lenses The Routine Vision Allowed Benefit for contact lenses is the actual charge.		
Medically Necessary	No Deductible required 100% of Routine Vision Allowed Benefit up to $285.00	80% of Routine Vision Allowed Benefit**
Elective contact lenses (in place of frames and lenses)	No Deductible required 100% of Routine Vision Allowed Benefit Unlimited up to $97.00	80% of Routine Vision Allowed Benefit**

*The Member is responsible for the difference between CareFirst's payment and the Health Care Provider's charge.

PEDIATRIC VISION CARE BENEFITS		
Covered Service	**CareFirst Payment***	
	Participating provider	**Non-Participating Provider**
Vision Exam	**Limitations** Benefits are available to pediatric Members eighteen (18) years old and younger.	
	No Deductible required 100% of Routine Vision Allowed Benefit	80% of Routine Vision Allowed Benefit**

*The Member is responsible for the difference between CareFirst's payment and the Health Care Provider's charge.
**Non-Participating Provider Covered Services are subject to the out-of-network Deductible set forth in the Schedule Of Benefits for the medical portion of the Evidence of Coverage.

PEDIATRIC VISION CARE BENEFITS		
Covered Service	**CareFirst Payment***	
	Participating provider	**Non-Participating Provider**
Frames, Lenses and Contact Lenses	**Limitations** Benefits are available to pediatric Members eighteen (18) years old and younger.	
Frames	No Deductible required 100% of Routine Vision Allowed Benefit up to $70.00 per frame	80% of Routine Vision Allowed Benefit
Lenses		
Covered Basic lenses are spectacle lenses (excluding specialty lenses with glare resistant treatment, ultraviolet coating, progressive lenses and transitional lenses and other special treatments). The Member may choose either traditional frames/lenses benefits or contact lenses per Benefit Period. **The Routine Vision Allowed Benefit for lenses and contact lenses is the actual charge.		
Basic Single vision	No Deductible required 100% of Routine Vision Allowed Benefit**	80% of Routine Vision Allowed Benefit**
Basic Bifocal		
Basic Trifocal		
Basic Lenticular		
Contact Lenses	**Limitations** Benefits for disposable contact lenses are limited to two (2) refills per Benefit Period.	
Medically Necessary	No Deductible required 100% of Routine Vision Allowed Benefit**	80% of Routine Vision Allowed Benefit**
Elective contact lenses (in place of frames and lenses)		

*The Member is responsible for the difference between CareFirst's payment and the Health Care Provider's charge.

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CARE SUPPORT PROGRAMS, PATIENT-CENTERED MEDICAL HOME, AND SUBSTANCE USE DISORDER PROGRAM ADDENDUM

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	Section B	Patient-Centered Medical Home services
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SECTION 3	**SCHEDULE OF BENEFITS**	

This Addendum is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. The effective date of coverage and termination date of coverage under this Addendum are the same as the effective date and termination date stated in the Group's Administrative Services Agreement for the benefits described herein.

The provisions of this Addendum do not apply to Members for whom Medicare is the primary carrier.

SECTION 1. DEFINITIONS

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

Care Support Programs are health care and wellness programs designed to promote the collaborative process of assessment, planning, and facilitation, and advocacy for options and services to meet a Qualified Individual's health needs through communication and available resources to promote quality cost-effective outcomes. Care Support Programs include but are not limited to; care coordination, case management, condition specific support, and enhanced monitoring.

Designated Provider means a provider or vendor contracted with CareFirst to provide services under CareFirst's Care Support Programs, and who has agreed to participate in Care Support Programs in cooperation with CareFirst for Members with complex chronic disease, high risk acute conditions or lifestyle behavior change.

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

Qualifying Individual, for purposes of the Care Support Program and Patient-Centered Medical Home Program, means a Member with certain conditions or complex health care needs, as determined by CareFirst, requiring care support and coordination of health services. The Member agrees to participate and comply with any and all elements in any given Care Support Program and Patient-Centered Medical Home Program.

Specialist, for purposes of this Addendum, means a licensed health care provider who is certified or trained in a specified field of medicine.

Substance Use Disorder means:

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

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

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

SECTION 2. DESCRIPTION OF COVERED SERVICES

Benefits are available for:

A. **Care Support Programs**

1. Benefits are available to Qualified Individuals to manage the care of certain complex chronic or high-risk acute diseases when provided by Designated Providers or through CareFirst and are covered at no cost to the Qualified Individual. Covered Services provided under Care Support Programs can include but are not limited to telemedicine services; case management services; expert consultation services; medication review services; medical equipment and monitoring services; and home health care services.

   a. Covered Services received as part of a Care Support Program are subject to applicable contract limits, Deductibles, Copayments, and/or Coinsurance as stated in the Schedule of Benefits.

   b. If the Qualified Individual's Evidence of Coverage is compatible with a federally-qualified Health Savings Account and the Qualified Individual has funded his/her HSA account during the Benefit Period, then the Qualified Individual will be responsible for any fees associated with the Member's participation in a Care Support Program until the annual Deductible has been met.

2. Exclusions and Limitations. Coverage will not be provided for the services listed in this amendment when rendered by non-Designated Providers.

B. **Patient-Centered Medical Covered Services**

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

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

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

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

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

C. **Substance Use Disorder Program**

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

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

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

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

2. There is no Copayment and/or Coinsurance associated with services provided under this program. The Deductible, if any, does not apply to Covered Service provided under this provision unless the Member's health benefit plan is a Health Savings Account (HSA)-compatible plan to which the Member has contributed to his/her HSA during the Benefit Period.

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PRESCRIPTION DRUGS BENEFITS RIDER FOR SPECIAL POPULATION MEMBERS

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

A. Definitions

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

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

1. The Pharmacy's actual charge; or

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

Preferred Preventive Drug means a Prescription Drug that is included on the CareFirst Preferred Preventive Drug List. Preferred Preventive Drugs do not include those medications which may be purchased Over-the-Counter.

Preferred Preventive Drug List means the list issued by CareFirst of certain preventive Prescription Drugs related to folic acid supplementation for women planning or capable of pregnancy, smoking cessation, oral fluoride supplementation for preschool children, and anemia prevention in children. Not all preventive Prescription Drugs are included on the Preferred Preventive Drug List. CareFirst may change this list periodically without notice to Members. A copy of the Preferred Preventive Drug List is available to the Member upon request.

Prescription Drug, for purposes of this Prescription Drugs Benefits for Special Population Members section, means: (i) a drug, biological or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;" (ii) drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst, if any of the categories stated herein are included on the Preferred Preventive Drug List.

Special Population Members means Members that are not enrolled in the Group's third party prescription drug coverage.

B. Eligibility

1. Benefits for Prescription Drugs under this section are available only to Special Population Members.

2. Benefits for Prescription Drugs under this section will terminate as follows:

   a. Effective on the date the Special Population Member enrolls in the Group's third-party prescription drug coverage; or

   b. As stated in the Eligibility Schedule of the Evidence of Coverage.

C. Covered Services

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

Pharmacy-dispensed Prescription Drugs	Prescription Drugs dispensed in the office of a Health Care Provider
Benefits are available for Pharmacy-dispensed Prescription Drugs.	Benefits are available for Prescription Drugs dispensed in the office of a Health Care Provider.

D. How the Prescription Drugs Benefits for Special Population Works

If the Member purchases a Prescription Drug Covered Service, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst or its designee up to the amount of the Allowed Benefit, minus any applicable Member payment amounts, as stated in the Schedule of Benefits. Members may be responsible for balances above the Allowed Benefit.

1. Claims must be submitted by the Member directly CareFirst's designee. It is the responsibility of the Member to make sure that proofs of loss are filed on time.

2. All benefits for Covered Services rendered by a non-Contracting Pharmacy will be payable to the Subscriber.

3. The Member is responsible for any difference between CareFirst's payment and the Non-Contracting Pharmacy's charge.

E. Notice of Claim

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

F. Claim Forms

CareFirst provides claim forms for filing proof of loss. If CareFirst does not provide the claim forms within 15 days after notice of claim is received, the Member is considered to have complied with the requirements of this Evidence of Coverage as to proof of loss if the Member.

Claims for Prescription Drug Benefits for Special Population Members must be submitted within twelve (12) months following the dates services were rendered.

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

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

G. Exclusions

In addition to the Exclusions contained in the Evidence of Coverage, for purposes of this Prescription Drug Benefits for Special Populations section, the following lists services or conditions for which benefits are not available under this section Evidence of Coverage. CareFirst will not provide a benefit for:

1. Any prescription drug that is not a Preferred Preventive Drug, except to the extent benefits for other Prescription Drugs are provided under the Evidence of Coverage.

This section shall not be construed to provide pharmacy-dispensed drug coverage beyond the extent provided herein.

H. Schedule of Benefits

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Prescription Drugs		
Preferred Preventive Prescription Drugs	**Limitations** Benefits for Prescription Drugs under this Prescription Drugs Benefits for Special Population Members section are limited to Covered Services for Preferred Preventive Prescription Drugs, as stated above.	
	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.
Other Prescription Drugs (except Preferred Preventive Prescription Drugs)	Benefits are available to the same extent as benefits provided for other Prescription Drugs under the Evidence of Coverage.	

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

CLAIMS PROCEDURES
Internal claims and Appeals and External Review processes

The Plan's Claims Procedures were developed in accordance with section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims for Benefits by Members as required by 29 CFR 2560.503-1 (the DOL claims procedure regulation), and the Public Health Service Act (PHS Act) requirements with respect to internal claims and Appeals and External Review processes for Group Health Plans that are not grandfathered health plans under §2590.715–1251 as set forth in §2590.715-2719. Except as otherwise specifically provided, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act. **NOTWITHSTANDING THIS PROVISION, NOTHING HEREIN SHALL BE CONSTRUED TO MEAN OR IMPLY THAT A NON-ERISA GROUP HEALTH PLAN HAS DEEMED ITSELF SUBJECT TO ERISA.**

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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 Claimant's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Was relied upon in making the benefit determination;

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

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

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

B. CLAIMS PROCEDURES

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

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

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

C. CLAIMS PROCEDURES COMPLIANCE

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

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

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

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

2. Civil Action. A Claimant is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA or under State law, as applicable.

D. CLAIM FOR BENEFITS

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

E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)

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

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

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

      1) Receipt of the specified information, or

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

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

      1) Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination.

The Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to Appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

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

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

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

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

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

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

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

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

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

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

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

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

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

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

e. In the case of an Adverse Benefit Determination:

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

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

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

g. That an External Review may be filed regarding an Appeal if:

1) The Plan or the Plan's Designee notifies the Claimant in writing that it has waived the requirement that its internal claims and Appeal process be exhausted before filing an External Review;

2) The Plan or the Plan's Designee has failed to comply with any of the requirements of its internal claims and Appeal process; or

3) The Claimant can demonstrate a compelling reason to do so as determined by the Commissioner.

h. That the Claimant has a right to file an External Review within four months after receipt of the Final Internal Adverse Benefit Determination;

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

j. A statement that the Health Advocacy Unit is available to assist the Claimant in both mediating and filing an Appeal and an External Review; and

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

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

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

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

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

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

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

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

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

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

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

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

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

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

4. Full and fair review. The Plan or the Plan's Designee shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and Appeals process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:

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

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

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

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. In the case of a benefit determination on review, 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 Claimant has a right to file an External Review with the Commissioner within 4 months after receipt of the benefit determination on review;

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

d. A statement that the Health Advocacy Unit is available to assist the Claimant with filing an External Review;

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 an External Review, the Claimant or a legally authorized designee of the Claimant will be required to authorize the release of any medical records of the Claimant that may be required to be reviewed for the purpose of reaching a decision on the External Review.

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

J. NOTICE

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

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

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

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

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

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

2. Form and manner of Notice.

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

b. Requirements

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

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

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

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

K. EXTERNAL REVIEW PROCESS

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

2. If a Claimant is in need of assistance, they may contact the appropriate agency as follows:

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

Additionally, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to a Claimant in need of assistance.

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

3. State of Maryland External Review Process

a. Definitions

The following terms shall have the meaning ascribed to such terms whenever such terms are used in the State of Maryland External Review Process.

Compelling Reason means a showing that the potential delay in receipt of a health care service until after the Claimant exhausts the internal Appeals process and obtains a Final Internal Adverse Benefit Determination could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the Claimant remaining seriously mentally ill with symptoms that cause the Claimant to be in danger to self or others.

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) A determination by the Plan that that an individual is not eligible for coverage under the Evidence of Coverage; or

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

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

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.

b. External Review Process

1) Within four months after the date of receipt of a Final Internal Adverse Benefit Determination, a Claimant may file an External Review with the Commissioner for review of the Final Internal Adverse Benefit Determination. A Claimant may file an External Review without first filing an Appeal with the Plan or the Plan's Designee only if the Coverage Decision involves a Claim Involving Urgent Care for which care has not been rendered.

2) A Claimant may file an External Review without first exhausting the internal claims and Appeals process if:

(a) In the case of an Adverse Benefit Determination, the Claimant provides sufficient information and supporting documentation to demonstrate a Compelling Reason.

(b) The External Review involves a Claim Involving Urgent Care for which care has not been rendered.

3) The remaining provisions of this paragraph K. apply to External Reviews regarding Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations.

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

(b) Except for a 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.3.b.4)(b) below, the Commissioner shall make a final decision on an External Review:

i. Within 45 days after an External Review is filed regarding a Pre-Service Claim;

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

iii. Within 24 hours after an External Review 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.3.b.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 External Review.

5) The Commissioner shall seek advice from an Independent Review Organization or medical expert for an External Review filed with the Commissioner that involves 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 External Review 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 Benefit Determination or Final Internal Adverse Benefit Determination, as applicable, is correct during the review of an External Review by the Commissioner, and in any hearing held regarding the External Review.

7) As part of the External Review, 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 an External Review, 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, or the Claimant to provide additional information as may be Relevant for the Commissioner to make a final decision on the External Review.

(b) The Commissioner shall allow the Claimant at least five working days to provide the additional information.

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

9) The Commissioner may request the Claimant to sign a consent form authorizing the release of the Claimant's medical records to the Commissioner that are needed in order for the Commissioner to make a final decision on the External Review.

10) Subject to paragraph H, a Claimant may file an External Review with the Commissioner if the Claimant does not receive the Plan's or the Plan Designee's Final Internal Adverse Benefit Determination within the following timeframes:

(a) Within 30 days after the filing date of a Final Internal Adverse Benefit Determination regarding a Pre-Service Claim;

(b) Within 45 working days after the filing date of a Final Internal Adverse Benefit Determination regarding a Post-Service Claim; and

(c) Within 24 hours after the receipt of a Final Internal Adverse Benefit Determination regarding a Claim Involving Urgent Care.

Note: the Health Advocacy Unit is available to assist the Claimant in both mediating and filing an External Review. Contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Maryland Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410- 528-1840 or 1-877- 261-8807
Fax: 410- 576-6571
http://www.marylandattorneygeneral.gov/Pages/CPD/heau