

**The County  
Commissioners of  
Worcester County**

**Traditional with Major Medical Option  
Prescription Drug 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.

Group Name: The County Commissioners of Worcester County Traditional with Major Medical;  
Prescription Drug Benefits

Group Number(s): K6PM, K6PP, K6PR, K6PS, K6PU, K6PW, K6PY, K6QA

**CareFirst of Maryland, Inc.**



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Chester E. Burrell  
President and Chief Executive Officer

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## DEFINITIONS

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

Allowed Benefit means:

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.

For a health care practitioner that has not contracted with CareFirst, the Allowed Benefit for a Covered Service is determined in the same manner as the Allowed Benefit for a Health Care Provider that has contracted with CareFirst. The benefit is payable to the Member or to the health care practitioner, at the discretion of CareFirst. If CareFirst pays the Member, 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.

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

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

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

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.

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

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

1. Includes evaluation and treatment; and
2. Incorporates:
  - a. Occupational Therapy, Physical Therapy, respiratory therapy, Speech Therapy;
  - b. Audiology, psychology, nursing care, medical social work.

Contract Renewal Date means the date on which the Group Contract renews and each anniversary of such date.

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

Conversion Contract means a non-group health benefits contract issued in accordance with state law to individuals whose coverage through the Group has terminated.

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

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

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

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

Dependent means a Member who is covered under the Evidence of Coverage as the eligible spouse or eligible child.

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

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

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

Evidence of Coverage means this agreement, and riders and amendments, if any, between the Group and CareFirst.

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

1. The Technology\* must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
3. The Technology must improve the net health outcome;
4. The Technology must be as beneficial as any established alternatives; and,
5. The improvement must be attainable outside the Investigational settings.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;
3. Not primarily for the convenience of a patient or Health Care Provider; and
4. Not more costly than an alternative service or frequency 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 the Premiums have been received by CareFirst.

Non-Participating or Non-Par Provider means any Health Care Provider that does not contract with CareFirst.

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

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

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

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

Participating Provider or Par Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members.

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 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.

Premium means the dollar amount the Group and/or Subscriber remits for health care benefits under this Evidence of Coverage.

Prescription Drug means a drug, biological or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;" and, drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.

Private Duty Nursing means Skilled Nursing Care services, ordered by a physician, 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. If the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same, then Skilled Nursing Care is not Medically Necessary. Skilled Nursing Care excludes services for performing the Activities of Daily Living (ADL) including but not limited to bathing, feeding, toileting.

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.

Skilled Nursing Care means Medically Necessary skilled care services, by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN). Skilled Nursing Care services must be based on a Plan of Treatment submitted by a Health Care Provider. Skilled Nursing Care visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if visits were not provided, a Member would have to be admitted to a hospital or Skilled Nursing Facility). Services of a home health aide, medical social worker or registered dietician may also be provided but must be performed under the supervision of a licensed professional (RN or LPN) nurse.

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

Sound Natural Teeth include teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers and crowns) and excludes any tooth replaced by artificial means (fixed or removable bridges, or dentures).

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

Subscriber means a Member who is an eligible employee or eligible participant of the Group, rather than a Dependent.

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Evidence of Coverage are selected by the Group and are stated in the Group Provisions. All types may not be available under a Group's Contract.

Waiting Period means the period of time that must pass before an employee or dependent is eligible to enroll under the terms of this Evidence of Coverage.

## **ELIGIBILITY AND ENROLLMENT**

### **2.1 Requirements for Coverage**

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

- A. The individual must be eligible for coverage either as a Subscriber or, if applicable, as a Dependent pursuant to the terms of the Evidence of Coverage;
- B. The individual must elect coverage during certain periods defined in the Evidence of Coverage;
- C. The Group must notify CareFirst of the election in accordance with the Group Contract; and,
- D. Payments must be made by or on behalf of the Member as required by the Group Contract.

### **2.2 Eligibility as a Subscriber**

To enroll as a Subscriber, the individual must meet the eligibility requirements established by the Group. These requirements are stated in the Eligibility Schedule.

### **2.3 Eligibility of Subscriber's Spouse**

If the Group has elected to include coverage for the Subscriber's spouse under this Evidence of Coverage (see Eligibility Schedule) then a Subscriber may enroll his or her spouse as a Dependent (spouse is a person of the opposite sex who is married to a Subscriber by a ceremony recognized by the law of the state or jurisdiction in which the Subscriber resides).

### **2.4 Eligibility of Children**

If the Group has elected to include coverage for the Subscriber's children under this Evidence of Coverage then a Subscriber may enroll a child as a Dependent as limited below (see Eligibility Schedule). To be eligible, the Dependent child must:

- A. Not have reached the Limiting Age for Dependent children as stated in the Eligibility Schedule;
- B. Be unmarried; and
- C. Be related to the Subscriber, in one of the following ways:
  - 1. The Subscriber's or spouse's Dependent child by birth or legal adoption;
  - 2. Under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, and who resides with, and is the dependent of, the Subscriber or spouse;
  - 3. A Dependent child who is the subject of a Medical Child Support Order or a Qualified Medical Support Order that creates or recognizes the right of the Dependent child to receive benefits under a parent's health insurance coverage;
  - 4. A grandchild who is in the court-ordered custody, and who resides with, and is the dependent of, the Subscriber or Dependent spouse.

- D. Children whose relationship to the Subscriber is not listed above, including, but not limited to grandchildren (except as provided above), foster children or children whose only relationship is one of legal guardianship (except as provided above) are not covered under this Evidence of Coverage, even though the child may live with the Subscriber and be dependent upon him or her for support.

2.5 **Limiting Age for Dependent Children.**

- A. Dependent children are eligible for coverage up to the Limiting Age for non-students, as stated in the Eligibility Schedule.
- B. Dependent children may be eligible beyond the Limiting Age if they meet the requirements for Student Dependents, as described below. Coverage will be provided up to the Limiting Age for Student Dependents as stated in the Eligibility Schedule.
  - 1. Student Dependent means a Dependent child who is enrolled and whose time is principally devoted to attending school (meets the requirements for full-time status, or shows evidence that attendance is a full-time endeavor).
  - 2. The Member must provide CareFirst with proof of the Dependent child's student status within 31 days after the Dependent child's coverage would otherwise terminate or within 31 days after the Effective Date of the Dependent child's coverage, whichever is later. CareFirst has the right to verify eligibility status.
- C. Coverage for unmarried incapacitated Dependent children/Student Dependents. A Dependent child/Student Dependent covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if:
  - 1. The Dependent child/Student Dependent is chiefly dependent for support upon the Subscriber or the Subscriber's Dependent spouse; and
  - 2. At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child/Student Dependent attained the Limiting Age.
  - 3. The Subscriber provides CareFirst with proof of the Dependent child's/Student Dependent's mental or physical incapacity within 31 days after the Dependent child's/Student Dependent's coverage would otherwise terminate. CareFirst has the right to determine whether the child is and continues to qualify as mentally or physically incapacitated.

2.6 **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.

A. **Open Enrollment Period**

- Open Enrollment changes will be effective on the Open Enrollment effective date stated in the Eligibility Schedule.
- 1. During the Open Enrollment period, the Group will provide an opportunity to all eligible persons to enroll in or transfer coverage between CareFirst and all other alternate health care plans available through the Group.
  - 2. In addition, Subscribers already enrolled in CareFirst may change their Type of Coverage (e.g. from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage.

**B. Newly Eligible Subscriber**

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

**C. Special Enrollment Periods**

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

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.

a. Special enrollment for certain individuals who lose coverage:

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

2) Individuals eligible for special enrollment.

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

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

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

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

ii) When dependent loses coverage.

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

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

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

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

- B) However, CareFirst is not required to enroll any other dependent unless the dependent satisfies the criteria of this paragraph a.2)ii), or the employee satisfies the criteria of paragraph a.2)i) of this section.
- 3) Conditions for special enrollment.
- i) Loss of eligibility for coverage. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph a)3)i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:
    - A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;
    - B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
    - C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual;
    - D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
    - E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes that individual.
  - ii) Termination of employer contributions. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

- iii) Exhaustion of COBRA continuation coverage. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph a)3)i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.
  - iv) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any dependent of the employee under this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)
- b. Special enrollment with respect to certain dependent beneficiaries:
- 1) Provided the Group provides coverage for dependents, CareFirst will permit the individuals described in paragraph b.2) of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
  - 2) Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph b.2)i), ii), iii), iv), v), or vi) of this section.
    - i) Current employee only. A current employee is described in this paragraph if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.
    - ii) Spouse of a participant only. An individual is described in this paragraph if either:
      - A) The individual becomes the spouse of a participant; or
      - B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.
    - iii) Current employee and spouse. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:

- A) The employee and the spouse become married; or
- B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.
- iv) Dependent of a participant only. An individual is described in this paragraph if the individual is a dependent of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.
- v) Current employee and a new dependent. A current employee and an individual who is a dependent of the employee, are described in this paragraph if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.
- vi) Current employee, spouse, and a new dependent. A current employee, the employee's spouse, and the employee's dependent are described in this paragraph if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

**D. Newly Eligible Children**

If the Group has elected to include coverage for the Subscriber's children under this Evidence of Coverage then a Subscriber may add a child outside the Open Enrollment period as described below. Other than the categories of children listed below, eligible children can only be added to this coverage during the Group's Open Enrollment period or special enrollment period except as stated under the Medical Child Support Orders section of this Evidence of Coverage. Enrollment will be effective as stated in the Eligibility Schedule.

The benefits applicable:

1. For a newborn child shall be payable from the moment of birth and shall continue for 31 days after the date of birth.
2. For an eligible grandchild shall be payable from the date the grandchild is placed in the court-ordered custody of the Subscriber or Dependent spouse and shall continue for 31 days after that date.
3. For a newly adopted child shall be payable from the date of adoption of the child and shall continue for 31 days after the date of adoption of the child.

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

4. For a minor for whom guardianship is granted by court or testamentary appointment shall be payable from the date of appointment and shall continue for 31 days after the date of court or testamentary appointment.

Coverage beyond 31 days may cost an additional Premium. This occurs when the addition of the child changes the Subscriber's Type of Coverage. When additional Premium is due the Subscriber must notify the Group within 31 days of the Effective Date and the additional Premium must be paid. Coverage will not be provided beyond the 31 days of automatic coverage when written notification enrolling the eligible child is not received within the 31-day period and the additional Premium is not paid.

Where the addition of a child does not change the Subscriber's Type of Coverage, CareFirst does not require notification within the first 31 days for coverage to continue beyond the 31-day period; however, CareFirst will not be able to properly process claims for the child until notice is given.

Coverage for a newborn child or newly adopted child or grandchild or a minor for whom guardianship is granted by court or testamentary appointment shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

**2.7 Enrollment Changes Following Spouse's Death or Spouse's Loss of Group Coverage**

A. CareFirst shall allow the addition of a Subscriber's dependent children to the Subscriber's Group Contract at any time and without evidence of insurability if:

1. The dependent children previously were covered under the policy or contract of the Subscriber's spouse and meet the eligibility provisions in this Group Contract; and
2. The Subscriber's spouse has died.

This section applies regardless of whether a Subscriber's dependent children are eligible for any continuation or conversion privileges under the policy or contract of the Subscriber's spouse.

The Subscriber must apply for enrollment provided under this section within six (6) months after the death of the Subscriber's spouse.

B. CareFirst shall allow the addition of a Subscriber's spouse and/or dependent children to the Subscriber's Group Contract at any time and without evidence of insurability if the Subscriber's spouse loses coverage under another group health insurance contract or policy because of the involuntary termination of the spouse's employment other than for cause.

The Subscriber must apply for enrollment provided under this section within six (6) months after the date on which the Subscriber's spouse's group health insurance contract or policy terminates. The dependent children must meet the eligibility provisions in this Group Contract.

**2.8 Eligibility of Individuals Covered Under Prior Continuation Provisions**

A. If, at the time the Group Contract is first issued, a person is covered under a federal or state required continuation provision of the Group's prior health insurance plan, the person will be considered eligible for coverage.

B. If, at the time an individual is first eligible for coverage, a person is covered under a federal or state required continuation provision of the person's prior health insurance plan, the person will be considered eligible for coverage.

C. The coverage will otherwise be subject to the eligibility requirements of the Group Contract.

**2.9 Clerical or Administrative Error**

Clerical or administrative errors by the Group or CareFirst in recording or reporting data will not confer eligibility or coverage upon individuals who are otherwise ineligible under this Evidence of Coverage, nor will such an error make an individual ineligible for coverage.

2.10 **Cooperation and Submission of Information**

CareFirst may require verification from the Group and/or Subscriber pertaining to the eligibility of a Subscriber or Dependent enrolled hereunder. The Group and/or Subscriber agree to cooperate with and assist CareFirst, including providing CareFirst with reasonable access to Group records upon request. In the event information and/or documents required to establish eligibility are not provided to CareFirst within 31 days following a written request to the Group or the Member, as applicable, coverage of such Members may be suspended by CareFirst. If the written request is sent to the Group and the Group fails to respond within 31 days, CareFirst will then send a copy of that request to the Member and allow the Member an additional 31 days to submit the information or documents required to establish eligibility directly to CareFirst. If such information and/or documents are not submitted by or on behalf of the Member within this 31-day period, CareFirst may suspend payment of claims.

2.11 **Proof of Eligibility**

CareFirst retains the right to require proof of relationships or facts to establish eligibility. CareFirst will pay the reasonable cost of providing such proof.

## MEDICAL CHILD SUPPORT ORDERS

### 3.1 Definitions

- A. Medical Child Support Order (MCSO) means an “order” issued in the format prescribed by federal law; and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An “order” means a judgment, decree or a ruling (including approval of a settlement agreement) that:
1. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia.
  2. Creates or recognizes the right of a child to receive benefits under a parent’s health insurance coverage; or establishes a parent’s obligation to pay child support and provide health insurance coverage for a child.
- B. Qualified Medical Support Order (QMSO) means a Medical Child Support Order issued under State law, or the laws of the District of Columbia and, when issued to an employer sponsored health plan, one that complies with Section 609(A) of the Employee Retirement Income Security Act of 1974, as amended.

### 3.2 Eligibility and Termination

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

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

- B. Enrollment for such a child will not be denied because the child:
1. Was born out of wedlock.
  2. Is not claimed as a dependent on the Subscriber's federal tax return.
  3. Does not reside with the Subscriber.
  4. Is covered under any Medical Assistance or Medicaid program.

- C. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to an MCSO/QMSO may not be terminated unless written evidence is provided to CareFirst that:
1. The MCSO/QMSO is no longer in effect;
  2. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage; or,
  3. If coverage is provided under an employer sponsored health plan;
    - a. The employer has eliminated family member's coverage for all employees; or
    - b. The employer no longer employs the Subscriber, except if the Subscriber elects continuation under applicable State or federal law the child will continue in this post-employment coverage.

### 3.3 **Administration**

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

- A. Send the non-insuring custodial parent ID cards, claims forms, the applicable certificate of coverage or member contract and any information needed to obtain benefits;
- B. Allow the non-insuring custodial parent or a Health Care Provider of a Covered Service to submit a claim without the approval of the Subscriber;
- C. Provide benefits directly to:
  1. The non-insuring parent;
  2. The Health Care Provider of the Covered Services; or
  3. The appropriate child support enforcement agency of any State or the District of Columbia.

## TERMINATION OF COVERAGE

### 4.1 **Disenrollment of Individual Members**

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

- A. CareFirst may terminate a Member's coverage as follows.
  - 1. Nonpayment of charges when due, including Premium contribution that may be required by the Group.
  - 2. The Member no longer meets the conditions of eligibility.
  - 3. Fraudulent use of CareFirst membership card on the part of the Member, the alteration or sale of prescriptions by the Member, or an attempt by the Subscriber to enroll non-eligible persons as Dependents.
- B. The Group is required to terminate the Subscriber's coverage and the coverage of the Dependents if the Subscriber is no longer employed by the Group or the Subscriber no longer meets the Group's eligibility requirements for coverage.
- C. 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.
- D. Coverage for the Subscriber and Dependents will terminate if the Subscriber cancels coverage through the Group or changes to another health benefits plan offered by the Group.
- E. Except in the case of a Dependent child enrolled pursuant to a Medical Child Support Order or Qualified Medical Support Order, the Dependents' coverage will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract, or makes a written request to CareFirst to remove an eligible Dependent from coverage.
- F. Coverage for Dependents will automatically terminate if they no longer meet the eligibility requirements of the Group Contract because of a change in age, status or relationship to the Subscriber. Coverage of an ineligible Dependent will terminate on the termination date set forth in the Eligibility Schedule.
- G. The Subscriber is responsible for notifying CareFirst (through the Group) of any changes in the status of Dependents that affect their eligibility for coverage. These changes include a divorce, the marriage of a Dependent child, or termination of a Student Dependent's status as a full-time student. 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.
- H. Subject to the Contestability of Coverage provision in the Group Contract, CareFirst can terminate a Member's coverage with 31 days prior written notice if CareFirst determines that the Member:
  - 1. Made an intentional misrepresentation of information that is material to the acceptance of the enrollment form. As a Member, you represent that all information contained in your enrollment form is true, correct and complete to the best of your knowledge and belief.
  - 2. The Member or the Member's representative made fraudulent misstatements related to coverage or benefits.

4.2 **Death of a Subscriber**

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

4.3 **Effect of Termination**

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

4.4 **Reinstatement**

Coverage will not reinstate automatically under any circumstances.

## CONTINUATION OF COVERAGE

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

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

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

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

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

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

#### C. Maryland Continuation of Coverage

When Maryland Continuation applies, the Member may continue coverage under the Evidence of Coverage as described below.

##### 1. Continuation for Spouse and Children after the Subscriber's Death

This provision applies in the event of the death of a Subscriber who was a resident of Maryland, was covered under the Group Contract or predecessor Group contract with the same employer for at least three months and whose coverage included one or more Dependents at the time of death. This provision also applies to a newborn child of the deceased Subscriber born to the surviving spouse after the Subscriber's death. When this provision applies, Dependents of the Subscriber may elect to remain covered under the Group Contract until the earliest of any of the following:

- a. 18 months after the date of the Subscriber's death;
- b. Failure to make timely payment for this continuation coverage;
- c. Enrollment in other group or non-group coverage;
- d. The date on which the Dependent becomes entitled to benefits under Medicare;
- e. The date on which the Dependent elects to terminate coverage under the Group Contract;
- f. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's death had not occurred, for example if the child marries or attains the Limiting Age; or
- g. The date on which the Group ceases to provide benefits to its employees under the Group Contract.

This continuation coverage must be elected, through submission of a signed election notification form to the Group, within 45 days after the Subscriber's death. The Dependents are responsible for payment through the Group of the full cost of this continuation coverage, which may include a reasonable administrative fee not to exceed 2% of premium, which is payable to and retained by the Group. No evidence of insurability is required.

2. **Continuation for Spouse and Children in the Event of Divorce**

This provision applies in the event of the divorce of a Subscriber who is a resident of Maryland and whose coverage included one or more Dependents at the time of divorce. This provision also applies to a newborn child of the Subscriber born to the former spouse after the date of divorce. When this provision applies, Dependents of the Subscriber may continue to be covered under the Group Contract until the earliest of any of the following:

- a. Termination of the Subscriber's coverage under the Group Contract;
- b. Failure to make timely payment for this continuation coverage;
- c. Enrollment of the Dependent in other group or non-group coverage;
- d. The date on which the Dependent becomes entitled to benefits under Medicare;
- e. With regard to the coverage of a spouse, the last day of the month in which the spouse remarries;
- f. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's divorce had not occurred, for example if the child marries or attains the Limiting Age;
- g. The effective date of an election by the Dependent to no longer be covered under the Group Contract; or
- h. The date on which the Group ceases to provide benefits to its employees under the Group Contract.

To receive this continued coverage, the Subscriber or the divorced spouse must notify the Group of the divorce no later than:

- a. Sixty (60) days following the divorce if, on the date of the divorce, the Subscriber is covered under the Group Contract or another group health plan offered by the Group; or
- b. Thirty (30) days following the effective date of the Subscriber's coverage under this Evidence of Coverage if, on the date of the divorce, the Subscriber was covered under a group health plan offered through a different employer.

The Subscriber or the former spouse of the Subscriber shall pay to the Group the full cost of the continuation coverage.

3. **State Continuation for Subscriber and Dependents in the Event of Voluntary or Involuntary Termination of Employment for Any Reason Other Than Cause**

This provision applies in the event of the voluntary and involuntary termination of employment of a Subscriber who is a resident of Maryland, who was terminated from employment for any reason other than cause and who was covered under the Group Contract or predecessor Group Contract with the same employer for at least three months prior to the termination of employment.

When this provision applies, the Subscriber and any Dependent who was covered under the Subscriber on the date of termination may elect to remain covered under the Group Contract until the earliest of any of the following:

- a. 18 months after the date of termination of the Subscriber's employment;
- b. Failure to make timely payment for this continuation coverage;
- c. Enrollment in other group or non-group coverage;
- d. The date on which the Subscriber becomes entitled to benefits under Medicare;
- e. The effective date of an election by the Subscriber to no longer be covered under the Group Contract;
- f. The date on which the employer ceases to provide benefits to its employees under a group contract.
- g. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's employment had not terminated, for example if the child marries or attains the limiting age.

This continuation coverage must be elected, through submission of a signed election notification form to the Group, within 45 days after termination of the Subscriber's employment. The Subscriber is responsible for payment through the Group of the full cost of this continuation coverage that may include a reasonable administrative fee not to exceed 2% of premium, which is payable to and retained by the Group. No evidence of insurability is required.

5.2 **Additional Right to Continue Group Coverage**

This provision applies if the following conditions are met:

- A. The Member was covered under the Group Contract for at least three months prior to termination;
- B. Coverage did not terminate for any of the following reasons:
  1. Eligibility for Medicare;
  2. Failure to pay premiums (or any applicable portion thereof);
  3. Attainment of any Limiting Age specified in the Group Contract.
- C. At the time of termination, the Member must not be:
  1. Enrolled in a Health Maintenance Organization;
  2. Covered by or eligible for coverage under another group policy;

- D. The Member must elect this continuation coverage through submission of a signed election notification form to the Group within 60 days after termination of coverage. The Group is responsible for notifying the Member of his or her continuation privileges on or before the termination date, but not more than 61 days before. If the notice is late, the election period will be extended for an additional period of time (at least 31 days). However, a late notice may not extend the election period beyond 90 days after the termination of coverage.
- E. When this provision applies, the Subscriber and any Dependent who was covered under the Subscriber on the date of termination may elect to remain covered under the Group Contract until the earliest of any of the following:
  - 1. Six months after the date of termination of the coverage;
  - 2. Failure to make timely payment for this continuation coverage;
  - 3. Enrollment in other group or non-group coverage;
  - 4. The date on which the Subscriber becomes entitled to benefits under Medicare;
  - 5. The effective date of an election by the Subscriber to no longer be covered under this Evidence of Coverage; or
  - 6. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under this Evidence of Coverage if the Subscriber's employment had not terminated, for example if the child marries or attains the Limiting Age.
- F. The Member will be responsible for payment through the Group of the full cost of this continuation coverage. If the Group Contract terminates before the end of the six-month period:
  - 1. The Member may continue his/her coverage by paying Premiums for the remainder of the period directly to CareFirst;
  - 2. CareFirst may impose a Premium surcharge (up to an additional 20 percent).

5.3 **Right to Continue Coverage under Only One Provision**

If a Member is eligible to continue coverage under the Evidence of Coverage under more than one continuation provision, the Member will receive only one such continuation coverage. The Member may select the continuation coverage of his or her choice.

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

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

- A. If a Member is Totally Disabled when his/her coverage terminates, CareFirst shall continue to pay covered benefits, in accordance with the Evidence of Coverage in effect at the time the Member's coverage terminates, for expenses incurred by the Member for the condition causing the disability until the earlier of:
  - 1. The date the Member ceases to be Totally Disabled; or
  - 2. 12 months after the date coverage terminates.

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

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

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

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

1. The date the Member is discharged from the hospital; or
2. 12 months after the date coverage terminates.

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

C. This section does not apply if:

1. Coverage is terminated because an individual fails to pay a required Premium;
2. Coverage is terminated for fraud or material misrepresentation by the individual; or
3. Any coverage provided by a succeeding health benefit plan is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit required under this section; and does not result in an interruption of benefits.

## CONVERSION PRIVILEGE

### 6.1 Conversion Privilege

#### A. Group Conversion

A Member who has been continuously covered for at least three (3) months under the Group Contract and any group policy providing similar benefits which it replaces shall be eligible for a Conversion Contract without evidence of insurability.

Conversion Contract means a non-Group health benefits contract issued in accordance with state law to individuals whose coverage under the Group Contract has terminated.

#### B. Notification

1. If a Member is entitled to continue coverage through a Conversion Contract, CareFirst will notify the Member of the conversion option on or before the date of termination of coverage, but no more than sixty-one (61) days before.
2. A Member who receives the timely notice of the conversion privilege shall be given the right to apply for a Conversion Contract up to forty-five (45) days after the date of the Member's termination under the Group Contract.
3. However, if CareFirst does not notify the Member of this conversion privilege or there is a delay in giving this notice, then the Member shall have at least thirty-one (31) days after the date of the notice in which to apply for a Conversion Contract, except that the time period within which a Member can elect to convert will not extend beyond ninety (90) days following the Member's termination date under the Group Contract.
4. Written notice presented to the Member or mailed by the Group to the last known address of the Member or mailed by CareFirst to the last known address of the Member as furnished by the Group shall constitute notice. Notice by mail which is returned undelivered does not constitute notice.
5. Conversion coverage is effective on the day following the date the Group Contract terminated or the Member's coverage under this Evidence of Coverage terminates and none of the exceptions below apply.
6. Benefits under a Conversion Contract may vary from the benefits under this Evidence of Coverage and CareFirst reserves all rights, subject to applicable requirements of law, to determine the form and terms of the Conversion Contract CareFirst issues.

#### C. Conversion Privilege Triggers

1. **Subscriber No Longer Eligible for Group Coverage**  
If the Subscriber's coverage terminates because the Subscriber is no longer an employee or participant of the Group or no longer meets the Group's eligibility requirements for health benefits coverage, the Subscriber may purchase a Conversion Contract to cover himself/herself and his/her covered Dependents.
2. **Upon Subscriber's Death**  
Following the death of a Subscriber, the enrolled spouse and Dependent children or, if there is no spouse, the covered Dependent children of the Subscriber, may purchase a Conversion Contract.
3. **Upon Termination of Marriage**  
If a spouse's coverage terminates because of legal separation, divorce or legal annulment, the spouse is entitled to purchase a Conversion Contract.

4. **Upon Termination of Coverage of a Child**  
If coverage of a Dependent child terminates because the child no longer meets the eligibility requirements, then the child is entitled to purchase a Conversion Contract.
5. **Upon Termination of the Group Contract by the Group**  
If coverage terminates because of the termination of the Group Contract by the Group, the Member may purchase a Conversion Contract if the Group has not provided for continued coverage through another health plan or other group insurance program offered by or through the Group.
6. **Upon Expiration of Continued Coverage**  
A Member may purchase a Conversion Contract upon expiration of continuation of coverage.

**D. Exceptions**

CareFirst will not issue a Conversion Contract if:

1. The Member is enrolled in a health maintenance organization, or is covered or eligible for coverage under another group policy which provides benefits substantially equal to the minimum benefits of the Conversion Contract.
2. The Member is eligible for Medicare.
3. Termination under the Group Contract occurred because:
  - a. The Member performed an act or practice that constitutes fraud in connection with the coverage;
  - b. The Member made an intentional misrepresentation of a material fact under the terms of coverage;
  - c. The terminated coverage under the Group Contract was replaced by similar coverage within thirty-one (31) days after the date of termination of the Group Contract; or,
  - d. The Member failed to pay a required premium.
4. The application shows the Member is covered under a group policy providing benefits substantially similar to the maximum benefits which the Member could elect under the Conversion Contract, or if the Member has other health benefits available at least equal to the level of benefits which would permit CareFirst to refuse to renew a Conversion Contract.
5. The Member is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy, or hospital or medical service subscriber contract, or medical practice, health maintenance organization, or other prepayment plan, or by any other plan or program.
6. The Member is covered for similar benefits under any arrangement of coverage for individuals in a group or in the military, on an insured or uninsured basis.
7. Similar benefits are provided for or available to the Member, pursuant to or in accordance with the requirements of any state or federal law.
8. CareFirst will not issue a Conversion Contract if benefits provided or available to the Member under items 5, 6, and 7, above, together with the Conversion Contract, would result in overinsurance according to CareFirst's standards on file with the Maryland Insurance Administration.

6.2 **Application**

CareFirst must receive the Member's application form, including full payment of the applicable premium, within forty-five (45) days after the effective date of termination, or within forty-five (45) days following CareFirst's notice, whichever is later.

## COORDINATION OF BENEFITS ("COB"); SUBROGATION

### 7.1 Coordination of Benefits ("COB")

#### A. Applicability

1. This Coordination of Benefits (COB) provision applies to this CareFirst Plan when a Member has health care coverage under more than one Plan.
2. If this COB provision applies, the Order Of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:
  - a. Shall not be reduced when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan; but
  - b. May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is described in the Effect on the Benefits section of this CareFirst Plan Evidence of Coverage.

#### B. Definitions

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

Allowable Expenses means a health care service or expense, including deductibles, coinsurance or copayments, that is covered at least in part by any of the Plans covering the Member, except as set forth below. This means that an expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense. When a Plan provides benefits in the form of services, (for example an HMO or a Closed Panel Plan) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

CareFirst Plan means this Evidence of Coverage.

Claim Determination Period means a calendar year unless a different benefit year basis is specifically stated in the Schedule of Benefits. However, it does not include any part of a year during which a Member has no coverage under this CareFirst Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Closed Panel Plan means a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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

The term Plan does not include:

1. An individually underwritten and issued, guaranteed renewable, specified disease policy;
2. An intensive care policy, which does not provide benefits on an expense incurred basis;
3. Coverage regulated by a motor vehicle reparation law;
4. The first \$100 per day of a Hospital indemnity contract; or,
5. An elementary and or secondary school insurance program sponsored by a school or school system.

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

1. When this CareFirst Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
2. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
3. When there are more than two Plans covering the Member, this CareFirst Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

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

#### C. **Order of Determination Rules**

1. **General**  
When there is a basis for a claim under this CareFirst Plan and another Plan, this CareFirst Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless;
  - a. The other Plan has rules coordinating benefits with those of this CareFirst Plan; and
  - b. Both those rules and this CareFirst Plan's rules require that this CareFirst Plan's benefits be determined before those of the other Plan.
2. **Rules**  
This CareFirst Plan determines its order of benefits using the first of the following rules which applies:
  - a. Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

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

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

b. Dependent child/parents not separated or divorced. When this CareFirst Plan and another Plan cover the same child as a dependent of different persons, called "parents:"

- 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.

However, if the other Plan does not have the rule described in 1) immediately above, but instead has a rule based upon the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. Dependent child/parents separated or divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- 1) First, the Plan of the parent with custody of the child;
- 2) Then, the Plan of the spouse of the parent with the custody of the child; and
- 3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses 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. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child follow the order of benefit determination rules outlined in paragraph describing Dependent child/parents not separated or divorced.

- e. Active/inactive employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- f. Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to Federal or State law also is covered under another Plan, the following shall be the order of benefits determination:
  - 1) First, the benefits of a Plan covering the person as an employee, member or Subscriber (or as that person's dependent);
  - 2) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- g. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter term.

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

- 1. **When this Section Applies**  
This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.
- 2. **Reduction in this CareFirst Plan's Benefits**  
The benefits under this CareFirst Plan will be reduced when the sum of:
  - a. The benefits that would be payable for the Allowable Expense under this CareFirst Plan in the absence of this COB provision; and
  - b. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this CareFirst Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this CareFirst Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this CareFirst Plan.

E. **Right To Receive And Release Needed Information**

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

F. **Facility Of Payment**

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

G. **Right Of Recovery**

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

1. The persons it has paid or for whom it has paid,
2. Insurance companies, or,
3. Other organizations.

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

7.2 **Employer or Governmental Benefits**

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

- A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
- B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

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

### 7.3 **Subrogation**

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

Recovery means to be successful in a lawsuit, to collect or obtain an amount; to obtain a favorable or final judgment; to obtain an amount in any legal manner; an amount finally collected or the amount of judgment as a result of an action brought against a third-party. A Recovery does not include payments made to the Member under the Member's Personal Injury Protection Policy. CareFirst will not recover medical expenses from a Subscriber unless the Subscriber or Member recovers for medical expenses in a cause of action.

- A. The Member shall notify CareFirst as soon as reasonably possible that a third-party may be liable for the injuries or illnesses for which benefits are being provided or paid.
- B. To the extent that actual payments made by CareFirst result from the occurrence that gave rise to the cause of action, CareFirst shall be subrogated and succeed to any right of recovery of the Member against any person or organization.
- C. The Member shall pay CareFirst the amount recovered by suit, settlement, or otherwise from any third-party's insurer, any uninsured or underinsured motorist coverage, or as permitted by law, to the extent that any actual payments made by CareFirst result from the occurrence that gave rise to the cause of action.
- D. The Member shall furnish information and assistance, and execute papers that CareFirst may require to facilitate enforcement of these rights. The Member shall not commit any action prejudicing the rights and interests of CareFirst.
- E. In a subrogation claim arising out of a claim for personal injury, the amount recovered by CareFirst shall be reduced by:
  - 1. Dividing the total amount of the personal injury recovery into the total amount of the attorney's fees incurred by the injured person for services rendered in connection with the injured person's claim; and
  - 2. Multiplying the result by the amount of CareFirst's subrogation claim. This percentage may not exceed one-third (1/3) of CareFirst's subrogation claim.
- F. On written request by CareFirst, a Member or Member's attorney who demands a reduction of the subrogation claim shall provide CareFirst with a certification by the Member that states the amount of the attorney's fees incurred.
- G. These provisions do not apply to residents of the Commonwealth of Virginia.

## **CERTIFICATE OF CREDITABLE COVERAGE**

### **8.1 Certificate of Creditable Coverage**

CareFirst will furnish a written certificate of creditable coverage via first-class mail.

### **8.2 Termination of CareFirst Coverage Prior to Termination of Coverage under the Group**

If an individual's coverage under this Group Contract ceases before the individual's coverage under the Group ceases, CareFirst will provide sufficient information to the Group (or to another party designated by the Group) to enable the Group (or other party), after termination of the individual's coverage under the Group, to provide a certificate that reflects the period of coverage under this Group Contract.

### **8.3 Individuals for Whom Certificate Must be Provided; Timing of Issuance**

#### **A. Issuance of Automatic Certificates**

##### **1. Qualified Beneficiaries Upon A Qualifying Event**

In the case of an individual entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the individual would lose coverage in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. CareFirst will provide the certificate no later than the time a notice is required to be furnished for a qualifying event relating to notices required under COBRA.

##### **2. Other Individuals When Coverage Ceases**

In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the individual ceases to be covered under this Group Contract. CareFirst will provide the certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of Premiums).

If an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease on the earliest date that a claim is denied due to the operation of the lifetime limit.

##### **3. Qualified Beneficiaries When COBRA Ceases**

In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), CareFirst will provide the certificate at the time the individual's coverage under the COBRA continuation coverage ceases. CareFirst will provide the certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of Premiums). CareFirst will provide the certificate regardless of whether the individual has previously received a certificate under paragraph 8.3 A.1. of this section.

#### **B. Any Individual Upon Request**

CareFirst will provide a certificate in response to a request made by, or on behalf of, an individual at any time while the individual is covered under this Group Contract and up to 24 months after coverage ceases. CareFirst will provide the certificate by the earliest date that CareFirst, acting in a reasonable and prompt fashion, can provide the certificate. CareFirst will provide the certificate regardless of whether the individual has previously received a certificate under paragraph 8.3 A.2., paragraph 2 or 8.3 A.1 of this section.

- C. If the Group retroactively terminates a Member beyond the period specified in the Group Contract, the Group agrees to indemnify and hold harmless CareFirst, its subsidiaries, officers, employees, agents and contractors from any and all claims, actions, damages, liabilities, and expenses whatsoever (including reasonable attorney fees) incurred or for which liability for the payment of has been determined, as a result of any act or omission on the part of the Group or its subsidiaries, officers, employees, agents and contractors in connection with or related to any failure to comply with any provisions of law, regulation or administrative directive, relating to or concerning the providing of timely and adequate Certificates of Coverage and as the same is more fully addressed and set forth under the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any future amendments thereto.

#### 8.4 **Combining Information For Families**

A certificate may provide information with respect to both a Subscriber and Dependents if the information is identical for each individual. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

## HOW THE PLAN WORKS

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

### **Appropriate Care & Medical Necessity**

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

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

### **Choosing a Provider**

#### Member/Health Care Provider Relationship

1. The Member has the exclusive right to choose a Health Care Provider. Whether a Health Care Provider is a Participating Provider or not relates only to method of payment, and does not imply that any Health Care Provider is more or less qualified than another.
2. CareFirst makes payment for Covered Services, but does not provide these services. CareFirst is not liable for any act or omission of any Health Care Provider.

#### Participating Providers

1. Claims will be submitted directly to CareFirst by the Health Care Provider.
2. CareFirst will pay benefits directly to the Health Care Provider.
3. The Member is responsible for any applicable Deductible and Coinsurance.

#### Referral to a Specialist

A Member may request a referral to a Specialist who is a Non-Participating Provider if:

1. The Member requires specialized Medical Care;
2. CareFirst does not contract with a Specialist to treat the condition or disease; and
3. The Specialist agrees to accept the Allowed Benefit as payment in full.

CareFirst will consider the Health Care Provider a Participating Provider.

#### Non-Participating Providers

1. Claims may be submitted directly to CareFirst or its designee by the Health Care Provider, or the Member may need to submit the claim. In either case, it is the responsibility of the Member to make sure that proofs of loss are filed on time.
2. All benefits for Covered Services rendered by a Non-Participating Provider will be payable to the Subscriber, or to the Health Care Provider, at the discretion of CareFirst.

3. In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a Qualified Medical Child Support Order, payment will be paid directly to the Department of Health and Mental Hygiene or the noninsuring parent if proof is provided that such parent has paid the Health Care Provider.
4. The Member is responsible for the difference between CareFirst's payment and the Non-Participating Provider's charge.

### **Notice of Claim**

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

### **Claim Forms**

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

### **Proofs of Loss**

In order to receive benefits for services rendered by a Non-Participating Provider, a Member must submit written proof of loss to CareFirst or its designee within the deadlines described below.

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

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

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

### **Time of Payment of Claims**

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

### **Claim Payments Made in Error**

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

### **Legal Action**

No legal action may be brought to recover on this Evidence of Coverage prior to 60 days after a written proof of loss for benefits has been filed and unless brought within three (3) years from the date the claim for benefits is required to be submitted.

### **Assignment of Benefits**

A Member may not assign his or her right to receive benefits or benefit payments under this Evidence of Coverage to another person or entity except for routine assignment of benefit payments to Participating Providers rendering Covered Services.

**Certificates**

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

**Notices**

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

**Privacy Statement**

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

## BLUECARD

Like all Blue Cross and Blue Shield Licensees, CareFirst participates in a program called “BlueCard.”

BlueCard, and BlueCard PPO, if applicable, enable Members to access on-site Blue Cross and/or Blue Shield Licensees’ (“Host Blues”) networks of contracted providers for services rendered outside the area CareFirst serves (service area).

To receive the maximum amount of coverage available, Members are responsible for ensuring out-of-area care is rendered by a Host Blue’s contracted providers. Whenever Members access health care services outside the geographic area CareFirst serves, the claim for those services may be processed through BlueCard and presented to CareFirst for payment in conformity with network access rules of the BlueCard Policies then in effect (“Policies”). Under BlueCard, when Members receive covered health care services within the geographic area served by a Host Blue, CareFirst will remain responsible to the Group for fulfilling CareFirst’s Group Contract obligations. The Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its providers and handling all interaction with its contracted providers.

The financial terms of BlueCard are described generally below.

### **Liability Calculation Method Per Claim**

The calculation of the Member liability on claims for covered health care services incurred outside the geographic area CareFirst serves and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price CareFirst pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue’s provider contracts. The negotiated price paid to a Host Blue by CareFirst on a claim for health care services processed through BlueCard may represent:

1. The actual price paid on the claim by the Host Blue to the Health Care Provider (“Actual Price”), or
2. An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue’s Health Care Providers or one or more particular providers (“Estimated Price”), or
3. An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue’s average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers (“Average Price”). An Average Price may result in greater variation to the Member and the Group from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or under-estimation of past prices. However, the amount paid by the Member is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either:

1. To use a basis for calculating the Member liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or
2. To add a surcharge.

When Members receive Covered Services in these states, the Members' liability for Covered Services will be calculated using these states' statutory methods. However, when this payment methodology results in a conflict of statutes or regulations between two states, CareFirst will comply with the statutes of the State of Maryland.

### **Return of Overpayments**

Under BlueCard, recoveries from a Host Blue or from contracted providers of a Host Blue can arise in several ways, including but not limited to anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require either correction on a claim-by-claim basis or on a prospective basis through an allocated reduction on future claims where recoveries cannot be linked to specific claims.

CareFirst will arrange to share such recoveries proportionately with Members in accordance with the terms and conditions of the Group Contract.

### **Utilization Management Requirements and BlueCard**

The Utilization Management Requirements of the Evidence of Coverage, if any, shall apply to BlueCard. The Member is responsible for:

1. Ensuring all Utilization Management Requirements are followed;
2. Any penalties for not complying with such requirements; and, or
3. Charges for out-of-area care CareFirst deems not Medically Necessary; and/or not covered under the Evidence of Coverage.

However, there may be instances where BlueCard claims are subject to the Host Blue's utilization management requirements and/or provider network rules, which may vary slightly from those stated in the Evidence of Coverage. Such variances may result from state laws that differ from those in Maryland or from contracts the Host Blue holds with its vendors/providers.

While CareFirst strives to provide consistent benefits for all Members, a Host Blue's utilization management requirements/vendors and provider network rules may sometimes affect a Member's benefits. Members accessing health care services outside the geographic area CareFirst serves should call 1-800-810-BLUE (2583) for that Host Blue's utilization management requirements/provider network rules prior to receiving services.

### **BlueCard Eligibility Claim Types**

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

## **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 important information about Deductibles, Out-of-Pocket Limit, and other features that affect Member coverage, including the annual Deductible, specific benefit limitations and, if applicable, the Lifetime Maximum.

## PREVENTIVE CARE

These are the minimum benefits offered. CareFirst may provide additional benefits in accordance with the CareFirst Preventive Guidelines.

### Child Wellness

Child wellness benefits are available for infants, children and adolescents (newborn up to age 18), for:

1. Each office visit in which a childhood or adolescent immunization, recommended by the Advisory Committee on Immunizations Practices of the Center for Disease Control, is administered, and the cost of the immunization;
2. Visits for the collection of adequate samples for hereditary and metabolic newborn screening and follow-up between birth and 4 weeks of age, the first of which is to be collected before 2 weeks of age;
3. Universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting;
4. Visits for and costs of age appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics;
5. Examinations including developmental assessments and parental anticipatory guidance; and,
6. Laboratory tests necessary to provide these services.

### Chlamydia and Human Papillomavirus Screening

#### A. Definitions

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

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

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

#### B. Covered Services

1. An annual routine Chlamydia Screening Test for:
  - a. Female Members who are under the age of 20 years if they are sexually active; and at least 20 years old if they have Multiple Risk Factors.
  - b. Male Members who have Multiple Risk Factors.
2. A human papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.

### Colorectal Cancer Screening

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

### **Mammography Screening**

Mammography screening (by low-dose mammography) for the presence of occult breast cancer provided by a Health Care Provider that is approved by the American College of Radiology, or certified/licensed by the State of Maryland will be covered as follows:

1. One baseline screening for a Member 35 to 39 years old;
2. One screening every twenty-four months or more frequently if recommended by a Health Care Provider for a Member 40-49 years old;
3. One screening every twelve months for a Member 50 years and over.

### **Osteoporosis Prevention and Treatment**

#### **A. 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:

1. Who is estrogen deficient and at clinical risk for osteoporosis;
2. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
3. Receiving long term glucocorticoid (steroid) therapy;
4. With primary hyperparathyroidism; or
5. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

#### **B. Covered Services**

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

### **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 40 and 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.

### **Routine Gynecological (GYN) Exam**

### **Routine Physical Exam (for a Member 18 years of age or older)**

## CLINICAL TRIAL PATIENT COST COVERAGE

### Clinical Trial Patient Cost Coverage

#### A. Definitions

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

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

NIH means the National Institutes of Health.

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

#### B. Covered Services

1. Benefits for Patient Cost to a Member in a Clinical Trial will be provided if the Member's participation in the Clinical Trial is the result of:
  - a. Treatment provided for a life-threatening condition; or
  - b. Prevention, early detection, and treatment studies on cancer.

2. Coverage for Patient Cost will be provided only if:
  - a. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for cancer; or
  - b. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for any other life-threatening condition;
  - c. The treatment is being provided in a Clinical Trial approved by one of the National Institutes of Health; or an NIH Cooperative Group or an NIH Center; or the FDA in the form of an Investigational new drug application; or the federal Department of Veterans Affairs; or, an institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office Of Protection From Research Risks of the NIH;
  - d. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
  - e. There is no clearly superior, non-Investigational treatment alternative; and,
  - f. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Investigational alternative.
3. Coverage is provided for the Patient Cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

## **CONTRACEPTIVE DEVICES AND DRUGS**

### **Contraceptive Devices and Drugs: Insertion or Removal; Exam**

The insertion or removal, and any Medically Necessary examination associated with the use of a contraceptive device and/or contraceptive drug approved by the FDA for use as a contraceptive and prescribed by a Health Care Provider.

## **DIABETES EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT TRAINING**

### **Diabetes Equipment, Supplies, and Self-Management Training**

1. Coverage will be provided for all Medically Necessary and medically appropriate equipment, diabetic supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician or other appropriately licensed Health Care Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.
2. If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified Health Care Provider whose scope of practice includes diabetes education or management.

Insulin syringes and other diabetic supplies are covered under Prescription Drug Benefits.

## **EMERGENCY SERVICES**

### **Emergency Services**

1. Outpatient hospital/physician Emergency Services/urgent care (initial treatment) within 72 hours of accident and trauma including accidental injury and trauma to the jaw, Sound Natural Teeth, mouth or face.
2. Outpatient hospital/physician Emergency Services/urgent care after 72 hours of accident and trauma.
3. Outpatient hospital/physician Emergency Services/urgent care for condition other than accident and trauma.
4. Follow-up care.
5. Ambulance services.

## GENERAL ANESTHESIA FOR DENTAL CARE

### General Anesthesia for Dental Care

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

1. If the Member is:
  - a. Seven years of age or younger, or developmentally disabled;
  - b. An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member; and
  - c. An individual for whom a superior result can be expected from dental care provided under general anesthesia.
2. Or, if the Member is:
  - a. Seventeen years of age or younger;
  - b. An extremely uncooperative, fearful, or uncommunicative individual;
  - c. An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and
  - d. An individual for who lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
3. Or, if the Member has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.
4. Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:
  - a. A fully accredited specialist in pediatric dentistry;
  - b. A fully accredited specialist in oral and maxillofacial surgery; and
  - c. A dentist who has been granted hospital privileges.
5. This provision does not provide benefits for general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.
6. This provision does not provide benefits for the dental care for which the general anesthesia is provided.

## **HABILITATIVE SERVICES**

### **Habilitative Services**

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

## HOME HEALTH CARE, HOME VISITS FOLLOWING CHILDBIRTH/TESTICLE REMOVAL

### Home Health Care

#### A. Definitions

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

1. The Member's physician establishes and approves in writing the Plan of Treatment recommending the Home Health Care service; and
2. Institutionalization of the Member would have been required, and deemed Medically Necessary by CareFirst, if Home Health Care was not provided.

#### Home Health Care Visits:

1. Each visit by a member of a Home Health Care team is considered one Home Health Care Visit; and
2. Up to four hours of Home Health Care service is considered one Home Health Care Visit.

#### B. Limitations

1. The Member must be confined to "home" due to a medical, non-psychiatric condition. "Home" cannot be an institution, convalescent home or any facility which is primarily engaged in rendering medical or Rehabilitative Services to the sick, disabled or injured persons.
2. The Home Health Care Visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if Home Health Care Visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).
3. The Member must require and continue to require Skilled Nursing Care or Rehabilitative Services in order to qualify for home health aide services or other types of Home Health Care. "Skilled Nursing Care," for purposes of Home Health Care, means care that requires licensure as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for performance.
4. Services of a home health aide, medical social worker or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).

### Home Visits Following Childbirth

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

1. For a Member and Dependent child(ren) who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or 96 hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the attending Health Care Provider;
2. For a Member who, in consultation with her attending Health Care Provider, requests a shorter hospital stay (less than 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated cesarean section):
  - a. One home visit following childbirth scheduled to occur within 24 hours after discharge;
  - b. An additional home visit following childbirth if prescribed by the attending Health Care Provider.

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

Home visits following childbirth must be rendered:

1. In accordance with generally accepted standards of nursing practice for home-care of a mother and newborn children;
2. By a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health.

**Home Visits Following the Surgical Removal of a Testicle**

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

1. One home visit following the surgical removal of a testicle scheduled to occur within 24 hours after discharge; and
2. An additional home visit following the surgical removal of a testicle if prescribed by the attending physician.

## HOSPICE CARE

### Hospice Care

#### A. Definitions

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

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

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

#### B. Covered Services

Hospice care benefits are available for a terminally ill Member (medical prognosis by a physician that the Member's life expectancy is six months or less) and his/her family (family is the spouse, parents, siblings, grandparents, child(ren) and or Caregiver).

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

## **INFERTILITY SERVICES**

### **Infertility Services**

Benefits are available for the diagnosis and treatment of Infertility including Medically Necessary, non-Experimental/Investigational artificial insemination/intrauterine insemination and in vitro fertilization.

Benefits for in vitro fertilization are available for a Member when:

1. The patient and the patient's spouse have a history of Infertility of at least 2 years' duration; or
2. 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;
3. The patient has been unable to attain a successful pregnancy through a less costly Infertility treatment for which coverage is available under the Evidence of Coverage; and
4. The procedure must be performed at a health care facility that conforms to the standards set by the American Society for Reproductive Medicine (ASRM), (formerly the American Fertility Society) or the American College of Obstetrics and Gynecology (ACOG).

The oocytes (eggs) must be naturally produced by the patient and fertilized with sperm naturally produced by the patient's spouse.

## INPATIENT/OUTPATIENT HEALTH CARE PROVIDER SERVICES

### Inpatient/Outpatient Health Care Provider Services

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

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

3. Surgery, including oral surgery limited to:
  - a. Surgery involving a bone, joint or soft tissue of the face, neck or head to treat a condition caused by disease, accidental injury and trauma, or congenital deformity, including cleft lip and cleft palate.
  - b. Services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a Member's condition, benefits will be based upon the lowest cost alternative.

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

- a. If the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.
  - b. If the additional procedures are not clinically integral to the primary procedure, including, but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the Evidence of Coverage based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines.
4. Surgical assistant if the surgery requires surgical assistance as determined by CareFirst.
  5. Anesthesia services by a Health Care Provider other than the operating surgeon.
  6. Chemotherapy, infusion therapy, radiation therapy, renal dialysis.
  7. Inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological and speech/language treatment for cleft lip or cleft palate or both.

8. Inpatient/outpatient diagnostic and treatment services provided and billed by a Health Care Provider, including diagnostic procedures, laboratory tests and x-ray services, including electrocardiograms, electroencephalograms, tonography, laboratory services, diagnostic x-ray services, and diagnostic ultrasound services.
9. Administration of injectable Prescription Drugs by a Health Care Provider.
10. Elective sterilization.
11. Acupuncture.
12. Allergy testing.
13. Spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.
14. Skilled Nursing Care.
15. Skilled Nursing Facility services.

## **MASTECTOMY—RELATED SERVICES**

### **Mastectomy—Related Services**

1. Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a nondiseased 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. For a Member who receives less than 48 hours of inpatient hospitalization following a mastectomy, or who undergoes a mastectomy on an outpatient basis:
  - a. One home visit scheduled to occur within 24 hours after discharge; and
  - b. An additional home visit if prescribed by the attending physician.

## MATERNITY SERVICES

### Maternity Services

1. Health Care Provider services including:
  - a. Prenatal visits;
  - b. Delivery of the child(ren);
  - c. Medically Necessary services for the normal newborn (an infant born at approximately 40 weeks gestation who has no congenital or comorbid conditions including but not limited to neonatal jaundice) including the admission history and physical, and discharge examination;
  - d. Medically Necessary inpatient/outpatient Health Care Provider services for a newborn with congenital or comorbid conditions;
  - e. Postnatal visits;
  - f. Circumcision.
2. Inpatient hospital services, including routine nursery care of the newborn child(ren), are available for:
  - a. A minimum of:
    - 1) 48 hours following an uncomplicated vaginal delivery;
    - 2) 96 hours following an uncomplicated cesarean section.
  - b. Up to four additional days of routine nursery care of the newborn child(ren) when the Member is required to remain in the hospital for Medically Necessary reasons.
3. Elective abortions.

## 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.

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

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

1. Specially formulated to have less than 1 gram of protein per serving; and
2. Intended to be used under the direction of a physician for the dietary treatment of an Inherited Metabolic Disease.

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

Medical Food means a food that is:

1. Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
2. Formulated to be consumed or administered under the direction of a physician.

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

Medical Supplies means items that:

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

Orthotic Device means orthoses and braces which:

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

Prosthetic Device means a device which:

1. Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or
2. Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
3. Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
4. Is prescribed by a Health Care Provider; and
5. Is removable and attached externally to the body.

B. Covered Services

**Durable Medical Equipment**

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

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

**Hair Prosthesis**

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

**Hearing Aids**

Covered Services for a minor Dependent child:

1. One Hearing Aid, prescribed, fitted and dispensed by a licensed audiologist for each hearing-impaired ear;
2. Non-routine services related to the dispensing of a covered Hearing Aid, such as assessment, fitting, orientation, conformity and evaluation.

**Medical Foods and Low Protein Modified Food Products**

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

1. Prescribed as Medically Necessary for the therapeutic treatment of Inherited Metabolic Diseases; and;
2. Administered under the direction of a physician.

**Medical Supplies****Nutritional Substances**

Enteral and elemental nutrition when Medically Necessary as determined by CareFirst.

**Orthotic Devices, Prosthetic Devices**

Benefits include:

1. Supplies and accessories necessary for effective functioning of Covered Service;
2. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and
3. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

## ORGAN AND TISSUE TRANSPLANTS

### Organ and Tissue Transplants

#### A. Definitions

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

#### B. Covered Services

1. When the recipient is a Member, organ transplant benefits are available for both the recipient and the donor;
2. When only the donor is a Member, organ transplant benefits are available for the donor only, and then only if the recipient has no benefits available for the donor.

Benefits are available for:

1. Human organ and tissue transplants: kidney, cornea, bone marrow and Related Services;
2. Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant;
3. Immunosuppressant maintenance drugs when prescribed for a covered transplant.

The organ transplant hospital must:

1. Have fair and practical rules for choosing recipients;
2. Have a written contract with someone that has the legal right to procure donor organs;
3. Conform to all laws that apply to organ transplants;
4. Be approved by CareFirst.

At least 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;
4. Prescribed treatment.

## PRESCRIPTION DRUGS

### Prescription Drugs

#### A. Definitions

Nicotine Replacement Therapy means a product that:

1. Is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and
2. Is approved by the FDA as an aid for the cessation of the use of tobacco products; and
3. Is obtained under a prescription written by an authorized prescriber.

Nicotine Replacement Therapy does not include any Over-the-Counter product that may be obtained without a prescription.

#### B. Covered Services

1. Except for a drug that may be obtained Over-the-Counter without a prescription any drug that:
  - a. Is approved by the FDA as an aid for the cessation of the use of tobacco products; and
  - b. Is obtained under a prescription written by an authorized prescriber.
2. Nicotine Replacement Therapy.
3. Injectable Prescription Drugs that require administration by a Health Care Provider.

#### C. Limitations

1. Prescription Drugs must be for the outpatient use of the Member;
2. Prescription Drugs must be dispensed in the office of a Health Care Provider.

## **SURGICAL TREATMENT OF MORBID OBESITY**

### **Surgical Treatment of Morbid Obesity**

#### **A. Definitions**

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

Morbid Obesity means:

1. A body mass index that is greater than 40 kilograms per meter squared; or,
2. Equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

#### **B. Covered Services**

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

## **TREATMENT OF MENTAL ILLNESSES, EMOTIONAL DISORDERS, AND DRUG AND ALCOHOL ABUSE**

### **Treatment of Mental Illnesses, Emotional Disorders, and Drug and Alcohol Abuse**

#### **A. Definitions**

Halfway House Facility means a transitional residential facility approved by the Department of Health and Mental Hygiene for the State of Maryland that offers treatment services at least 4 hours per week for the treatment of mental illnesses, emotional disorders and drug and alcohol abuse.

Intensive Outpatient means having the capacity for planned, structured, service provision of at least two hours per day and three days per week, although some Members may need to attend less often. Encounters are usually comprised of coordinated and integrated multidisciplinary services.

Medication Management means visits with a Health Care Provider for prescription, use, and review of medication that include no more than minimal psychotherapy.

Partial Hospitalization means the provision of medically supervised intensive or intermediate short-term treatment:

1. In a licensed or certified facility or program;
2. For treatment of mental illnesses, emotional disorders, and drug and alcohol abuse; and
3. For a period of less than 24 hours but more than 4 consecutive hours in a day.

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

1. Provided to a Dependent child or an adult Member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the Member's ability to function in the community;
2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
3. Provided outside of the Member's residence on a short-term basis in a community-based residential setting; and
4. Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.

#### **B. Covered Services**

1. Inpatient/outpatient treatment, including outpatient psychological and neuropsychological testing for diagnostic purposes, of mental illnesses, emotional disorders, and drug and alcohol abuse;
2. Residential Crisis Services;
3. Medication Management;
4. Partial Hospitalization;
5. Intensive Outpatient services;
6. Halfway House Facility.

## **TREATMENT OF TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION**

### **Treatment of Temporomandibular Joint (TMJ) Dysfunction**

Medically Necessary conservative treatment, as determined by CareFirst.

## UTILIZATION MANAGEMENT REQUIREMENTS

### **Outpatient PreAuthorization Program**

#### Plan of Treatment

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

1. A health care practitioner must complete and submit a Plan of Treatment.
2. CareFirst must approve the Plan of Treatment before benefits for treatment can begin or continue.
3. Approval for coverage of any service is based on Medical Necessity as determined by CareFirst.
4. The Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by the Health Care Provider.
5. Services for which CareFirst must approve a Plan of Treatment:
  - a. **Infertility Services**  
If the Plan of Treatment is not submitted, benefits will be denied.  
  
If the Plan of Treatment is submitted after commencing Infertility services, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.
  - b. **Home Health Care**  
If the Plan of Treatment is not submitted, benefits will be denied.  
  
If the Plan of Treatment is submitted late (48 hours after commencing Home Health Care), the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time.
  - c. **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.
  - d. **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%.

- e. **Habilitative Services**  
CareFirst must approve the Plan of Treatment after the 1<sup>st</sup> visit. This visit limitation is per lifetime, per Member while covered by CareFirst. If a Member requires additional treatment, a Plan of Treatment is required prior to the first visit if the Member reached the lifetime visit limit.

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.

- f. **Rehabilitative Services: Occupational Therapy; Physical Therapy; Speech Therapy**  
CareFirst must approve the Plan of Treatment after the 10<sup>th</sup> visit. This visit limitation is per lifetime, per Member while covered by CareFirst. If a Member requires additional treatment, a Plan of Treatment is required prior to the first visit if the Member reached the lifetime visit limit.

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.

### **Hospital Certification & Review**

1. CareFirst may perform the review or may appoint a review agent. The telephone number for obtaining review is printed on the back of the membership card.
2. The reviewer will screen the available medical documentation for the purpose of determining the Medical Necessity of the admission, length of stay, appropriateness of setting and cost effectiveness and will evaluate the need for discharge planning.
3. Procedures which are normally performed on an outpatient basis will not be approved to be performed on an inpatient basis, unless unusual medical conditions are found through Hospital Certification & Review.
4. Pre-operative days will not be approved for procedures unless Medically Necessary.
5. The reviewer will assign the number of days certified based on the clinical condition of the Member and notify the Health Care Provider of the number of days approved.
6. CareFirst's payment will be based on the inpatient days approved by the reviewer.
7. CareFirst will provide outpatient benefits for Medically Necessary Covered Services when the reviewer does not approve services on an inpatient basis.
8. Hospital Certification & Review is applicable to Maternity Services; however, it does not apply for the 48-hour and 96-hour minimum lengths of stay, as stated in the Description of Covered Services, Maternity Services and, the non-compliance penalty is waived.

#### Non-Emergency (Elective) Admissions

1. The Member must provide any written information requested by the reviewer for Hospital Certification & Review of the admission at least 24 hours prior to the admission.
2. The reviewer will make all initial determinations on whether to approve an elective admission within two working days of receipt of the information necessary to make the determination and shall promptly notify the attending Health Care Provider and Member of the determination.

CareFirst will not provide benefits for room and board charges for an elective admission which is not Medically Necessary: the Member is responsible for the room and board charges. CareFirst will provide benefits for Medically Necessary hospital ancillary services only.

#### Emergency (Non-Elective) Admissions

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

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

- a. The Member's insurance status; and
  - b. The reviewer's emergency admission notification requirements.
2. For an involuntary or voluntary inpatient admission of a Member determined by the Member's physician or psychologist, in conjunction with a member of the medical staff of the hospital who has privileges to admit patients to be in imminent danger to self or others, the reviewer may not render an Adverse Decision as to the Member's admission:
    - a. During the first 24 hours the Member is in an inpatient facility; or
    - b. Until the reviewer's next business day, whichever is later.

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

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

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

- a. A Member will have to pay:
  - 1) All charges for any care received as of the date the Member receives notice by the hospital attending Health Care Provider, or CareFirst that further care is not Medically Necessary if the Member continues the inpatient stay.
  - 2) Non-Participating Providers if a non-elective admission results in payment denial.
- b. A Member will not have to pay Participating Providers:
  - 1) If the Member is admitted and the admission is not Medically Necessary;
  - 2) If a non-elective admission results in payment denial.

#### Program Monitoring

1. The Member's medical record will be reviewed by the reviewer.
2. The hospital may be requested to evaluate the medical records and respond to the reviewer if there is a delay in which care is not provided when ordered or otherwise requested by a Health Care Provider in a timely fashion or other delay.
3. During and after discharge, the reviewer may review the medical records to:
  - a. Verify that the services are covered under the Evidence of Coverage;
  - b. Ensure that the Health Care Provider is substantially following the Plan of Treatment.

#### Notice and Appeals

1. Written notice of any Adverse Decision is sent to the Health Care Providers and Member.
2. The Member or the Health Care Providers have the right to appeal Adverse Decisions in writing to CareFirst.
  - a. If the attending Health Care Provider believes the Adverse Decision warrants immediate reconsideration, the reviewer will afford the Health Care Provider the opportunity to seek a reconsideration of the Adverse Decision by telephone within 24 hours of the Health Care Provider's request.
  - b. For instructions on how to appeal an Adverse Decision, refer to the Benefit Determinations and Appeals Procedures and Grievance and Appeal Procedures of this Evidence of Coverage.

**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.

**Second Surgical Opinion**

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

## EXCLUSIONS

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

CareFirst will not provide a benefit for:

- Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.
- Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst.
- Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons.

This exclusion does not apply to:

1. Medicaid;
  2. Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland;
  3. Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.
- Services that are not specifically shown in this Evidence of Coverage as a Covered Service or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a Participating Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.
  - Routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
  - Routine dental care such as services, supplies, or charges directly related to the care, filling, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
  - Cosmetic services (except for Mastectomy—Related Services and services for cleft lip or cleft palate or both).
  - Treatment rendered by a Health Care Provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
  - Outpatient Prescription Drugs unless otherwise stated.

- All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services. Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception 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.
- Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- Lifestyle improvements, including, but not limited to smoking cessation, health education classes and self-help programs except as stated in the Description of Covered Services.
- Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment.
- Treatment for weight reduction and obesity except for the surgical treatment of Morbid Obesity.
- Routine eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.
- Services furnished as a result of a referral prohibited by law.
- Any service related to recreation activities. This includes, but is not limited to, sports, games, equestrian activities and athletic training, even though such services may be deemed to have therapeutic value.
- Non-medical, Health Care Provider services, including, but not limited to:
  1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.
  2. Administrative fees charged by a Health Care Provider to a Member to retain the Health Care Provider's medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are limited to Covered Services rendered to a Member by a Health Care Provider.
- Educational therapies intended to improve academic performance.
- Vocational rehabilitation, and employment counseling.
- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services) except General Anesthesia & Associated Hospital or Ambulatory Surgical Facility Services for Dental Care.
- Separate billings for health care services or supplies furnished by an employee of a Health Care Provider which are normally included in the Health Care Provider's charges and billed for by them.
- Services that are non-medical in nature, including, but not limited to personal hygiene, Cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.

- Personal comfort items, even when used by a member in an Inpatient hospital setting, such as telephones, televisions, guest trays, or laundry charges.
- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living, e.g., bathing, toileting, and eating (care which may be provided by persons without professional medical skills or training).
- Self-care or self-help training designed to enable a member to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated.
- Travel, whether or not advised by a health care practitioner. Limited travel benefits related to an organ transplant may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
- Services intended to increase the intelligence quotient (IQ) of Members with mental retardation 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.
- Dietary or nutritional counseling except as stated in the Description of Covered Services, Diabetes Equipment, Supplies, and Self-Management Training.
- Tinnitus maskers, purchase, examination, or fitting of Hearing Aids except as stated in the Description of Covered Services, Hearing Aids. Hearing care benefits for an adult Member may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
- Services related to human reproduction other than specifically described in this Evidence of Coverage including, but not limited to maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a Member.
- Blood products and whole blood when donated or replaced.
- Oral surgery, dentistry or dental processes unless otherwise stated.
- Treatment of temporomandibular joint disorders unless otherwise stated.
- Premarital exams.
- Routine or periodic physical or gynecological (GYN) exams or diagnostic services related to them unless otherwise stated.
- 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 Worker's 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.
- Illnesses resulting from an act of war.
- Charges used to satisfy a Member's dental care, Prescription Drug, or vision care benefits Deductible, if applicable, or balances from any such programs.
- Legal services.
- Allergy immunotherapy.
- Hearing care except as otherwise stated.

The following are exclusions to the services listed in the Description of Covered Services. CareFirst will not provide a benefit for:

**General Anesthesia and Associated Hospital or Ambulatory Surgical Facility Services for Dental Care**

Dental care for which general anesthesia is provided.

**Habilitative/Rehabilitative Services**

1. Services delivered through early intervention and school services.
2. Habilitative Services for a Member 19 years and older.

**Home Health Care**

1. Rental or purchase of renal dialysis equipment and supplies.
2. "Meals-on-Wheels" type food plans.
3. Domestic or housekeeping services.
4. 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**

1. Any services other than palliative treatment.
2. Rental or purchase of renal dialysis equipment and supplies.
3. Domestic or housekeeping services.
4. "Meals on Wheels" or similar food arrangements.

**Infertility Services**

1. When the Member or spouse has undergone elective sterilization with or without reversal.
2. When any surrogate or gestational carrier is used.
3. When the service involves the use of donor eggs and sperm.
4. When the service involves the participation of a Domestic Partner or common law spouse, except in states that recognize the legality of those relationships.

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

**Inpatient/Outpatient Health Care Provider Services**

1. Medical care for inpatient stays that are primarily for Rehabilitative Services, any diagnostic service, and/or observation. Rehabilitative Services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
2. Inpatient Private Duty Nursing.
3. Procedures to reverse sterilization.

**Organ and Tissue Transplants: Kidney, Cornea, Bone Marrow**

1. Any and all services for or related to any organ transplants except those specifically stated in the Description of Covered Services. Additional organ transplant benefits may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.
2. Services or supplies not shown in the Evidence of Coverage as a Covered Service, including services or supplies for, or related to surgical organ transplant procedures not specifically listed as covered.
3. Any organ transplant or procurement done outside the continental United States.
4. An organ transplant relating to a condition arising from and in the course of employment.
5. Organ and tissue transplant Covered Services if there are research funds to pay for the Covered Services.
6. Expenses Incurred for the location of a suitable donor, e.g., National Bone Marrow Registry, search of a population or mass screening.

**Prescription Drugs**

1. Routine immunizations and boosters.
2. Administration of injectable Prescription Drugs by a Health Care Provider.

## **Treatment of Mental Illnesses, Emotional Disorders, and Drug and Alcohol Abuse**

1. Marital counseling.
2. When a Member is receiving Partial Hospitalization:
  - a. Services, supplies and care of any kind not directly related to Partial Hospitalization;
  - b. Laboratory or diagnostic services not directly related to Partial Hospitalization;
  - c. Cost of transport or admission to any field activity;
  - d. Meals that are not provided on the Partial Hospitalization Health Care Provider's premises;
  - e. Any service or activity to which a patient is referred that is not part of the Partial Hospitalization.
3. Wilderness programs.
4. Boarding schools.

**ELIGIBILITY SCHEDULE**

<b>ELIGIBILITY</b>	
The following persons are eligible for benefits under this Evidence of Coverage:	
Subscriber	<p>An employee eligible for the provisions of the Family and Medical Leave Act of 1993, as stated therein</p> <p><b>NOTE:</b> A wage earning employee is a person who is compensated by the Group for work/services performed in accordance with applicable federal and state wage and hour laws, which compensation is reported to the Internal Revenue Service by Form W-2 and the Department of Business and Economic Development by Form DEED/AU-16.</p> <p>A 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</p> <p>A person eligible under guidelines defined by the Group: The County Commissioners of Worcester County.</p>
Spouse	Coverage for a spouse is available.
Domestic Partner	Coverage for a Domestic Partner is not available.
Dependent Children	<p>Coverage for Dependent children is available.</p> <p>Coverage for children of a Domestic Partner is not available.</p>
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
<p>Limiting Age for Dependent children</p> <p>The Limiting Age is not applicable to unmarried incapacitated Dependent children/incapacitated Student Dependents</p>	Up to age 26

<b>EFFECTIVE DATES</b>	
Open Enrollment	The Group's Contract Date
Newly eligible Subscriber	<p>The date defined by the Group, which is: the enrollment period defined by the Group during which a Subscriber must apply for coverage under this Evidence of Coverage.</p> <p>Within 31 days after any event which, in the judgement 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 following acceptance of the enrollment form by CareFirst</p> <p>Within 31 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 of the month following acceptance of the enrollment form by CareFirst</p> <p>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</p>

**EFFECTIVE DATES**

Dependents of a newly eligible Subscriber	<p>The date defined by the Group, which is: the enrollment period defined by the Group during which a Subscriber must apply for coverage under this Evidence of Coverage.</p> <p>Within 31 days after any event which, in the judgement of the Plan Administrator qualifies as a status change or other allowable change under Section 125 of the Internal Revenue Code (family status changes) Dependents of a new Subscriber are eligible for coverage effective the first of the month following acceptance of the enrollment form by CareFirst</p> <p>Within 31 days of an employee taking or returning from an unpaid leave of absence (Family and Medical Leave Act of 1993) Dependents of a new Subscriber are eligible for coverage effective the first of the month following acceptance of the enrollment form by CareFirst</p>
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<b>EFFECTIVE DATES</b>	
Newly eligible spouse	The date of marriage
Newly eligible Dependent child	<p>Newly born Dependent child: the date of birth.</p> <p>Adopted Dependent 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.</p> <p>Testamentary or court appointed guardianship of a Dependent child: the date of appointment.</p> <p>Dependent child who is the subject of a Medical Child Support Order or Qualified Medical Support Order that creates or recognizes the right of the Dependent child to receive benefits under a parent's health insurance coverage:</p> <p><u>Medical Child Support Order</u>: the date specified in the Medical Child Support Order.</p> <p><u>Qualified Medical Support Order</u>: the date specified in the Medical Child Support Order.</p> <p>A grandchild who is in the court-ordered custody, and who resides with, and is the dependent of, the Subscriber or spouse: the date of placement of a grandchild in the court-order custody of the Subscriber or spouse.</p>
Dependent child following spouse's death or Dependent child or spouse following spouse's loss of group coverage	<p>If notice was given w/in 31 days after coverage was lost: The date prior coverage terminated.</p> <p>After the 31<sup>st</sup> day: The first of the month following acceptance of the application.</p>
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 above for a Dependent of a Newly eligible Subscriber

**SPECIAL ENROLLMENT PERIODS**

<p>Special enrollment for certain individuals who lose coverage</p>	<p>The employee must notify the Group, and the Group must notify CareFirst no later than 30 days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.</p> <p>A new Subscriber and/or his/her Dependents is effective on the first of the month following acceptance of the enrollment form by CareFirst</p>
<p>Special enrollment for certain dependent beneficiaries</p>	<p>The employee must notify the Group, and the Group must notify CareFirst during the 31-day special enrollment period beginning on the date of the marriage, birth, or adoption or placement for adoption</p> <p>A new Subscriber and/or his/her Dependents is effective as follows:</p> <p>In the case of marriage: the date of marriage.</p> <p>In the case of a newly born child: the date of birth.</p> <p>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.</p>

<b>TERMINATION OF COVERAGE</b>	
Subscriber no longer eligible	A Subscriber and his/her Dependents will remain covered until the end of the month the Subscriber's eligibility ceases under the terms of the Evidence of Coverage
Dependent child	A Dependent child will remain covered until the end of the calendar year 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 of charges	Coverage will terminate on the date stated in CareFirst's written notice of termination
Fraudulent use of CareFirst membership card on the part of the Member, the alteration or sale of prescriptions by the Member, or an attempt by the Subscriber to enroll non-eligible persons as Dependents	Coverage will terminate on the date stated in CareFirst's written notice of termination
Subscriber cancels coverage through the Group or changes to another health benefits plan offered by the Group	Coverage will terminate at the end of the month the Subscriber cancels coverage through the Group or changes to another health benefits plan offered by the Group
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 Qualified Medical Support Order)	Coverage will terminate at the end of the month the Subscriber changes the Type of Coverage to an Individual or other non-family contract
Death of a Subscriber	Coverage of any Dependents will terminate at the end of the month in which the Subscriber dies

## SCHEDULE OF BENEFITS

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. 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. 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.

All inpatient days are combined under this Evidence of Coverage.

1. Blue Cross benefits are provided for Covered Services rendered by a hospital , Skilled Nursing Facility, or ambulatory surgical facility. Blue Cross does not provide benefits for health care practitioner services. The CareFirst payment for Blue Cross Covered Services rendered by a Participating Provider is 100% of the Allowed Benefit. The CareFirst payment for Blue Cross Covered Services rendered by a Non-Participating Provider is 80% of the Allowed Benefit.
2. Blue Shield benefits are provided for Covered Services rendered by a health care practitioner. Blue Shield does not provide benefits for hospital , Skilled Nursing Facility, or ambulatory surgical facility services. The CareFirst payment for Blue Shield Covered Services is 100% of the Allowed Benefit.
3. Major Medical benefits are provided for Covered Services rendered by any Health Care Provider. The CareFirst Payment for Major Medical Covered Services, after the Deductible, if applicable, is 80% of the Allowed Benefit unless otherwise stated.

Major Medical benefits are provided for certain services that are not covered under Blue Cross/Blue Shield, such as Ambulance Services, Durable Medical Equipment and office visits for Preventive Care or an illness.

Major Medical benefits are provided for Covered Services in excess of Blue Cross/Blue Shield maximums/limitations, e.g., Home Health Care.

Major Medical benefits supplement Blue Cross/Blue Shield benefits by providing coverage for inpatient days in excess of those covered under Blue Cross/Blue Shield.

Every attempt has been made to identify the CareFirst Payment as Blue Cross/Blue Shield, or Major Medical. The CareFirst Payment is determined by the type of Health Care Provider, the type of service rendered, the place where the service is rendered, and whether any applicable Blue Cross/Blue Shield benefit maximums/limitations have been met. For example, the CareFirst Payment for the following mastectomy—related services would be:

Surgery: Blue Cross/Blue Shield

Diagnostic services: Blue Cross/Blue Shield

Outpatient medical care: Major Medical

Unless otherwise stated for a particular Major Medical Covered Service:

**Benefit Period Deductible**

The Benefit Period Deductible of \$300 for an individual and \$600 for a family applies to all benefits.

The Deductible is calculated based on the Allowed Benefit of Covered Services. Amounts in excess of the Allowed Benefit do not contribute to the Deductible.

The family Deductible amount is calculated in the aggregate. No family Member will be charged more than the individual Deductible amount. Any Type of Coverage which is not individual is considered family.

**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.

<b>OUT-OF-POCKET MAXIMUM</b>		
<b>Individual</b>		
\$1,000		
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.		
The following amounts are included/excluded from the Out-of-Pocket Maximum:	<b>Included</b>	<b>Excluded</b>
Amounts in excess of the Allowed Benefit	No	Yes
Deductible	No	Yes
Coinsurance (Member's share)	Yes	No

**Lifetime Maximum**

The Lifetime Maximum is unlimited per person.

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Preventive Care</b>			
Child wellness		Not covered at this level	No Deductible required 80% of Allowed Benefit
Universal hearing screening of newborns		Benefits are available to the same extent as benefits provided for inpatient/outpatient Health Care Provider services	
Chlamydia and human papillomavirus screening		100% of Allowed Benefit	Not covered at this level
Colorectal cancer screening		Not covered at this level	80% of Allowed Benefit
Mammography screening		Benefits are available to the same extent as benefits provided for diagnostic services	
Osteoporosis prevention and treatment		100% of Allowed Benefit	Not covered at this level
Prostate cancer screening		100% of Allowed Benefit	Not covered at this level
Routine gynecological (GYN) exam	Benefits are limited to one visit per Benefit Period.	Not covered at this level	80% of Allowed Benefit
Routine physical exam	Benefits are limited to one visit per Benefit Period.	Not covered at this level	80% of Allowed Benefit up to \$200 maximum per exam

Covered Service	Limitations	CareFirst Payment
<b>Clinical trial Patient Cost coverage</b>		Benefits are available to the same extent as benefits provided for other illnesses

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Contraceptive devices and drugs</b>		Not covered at this level	Benefits are available to the same extent as benefits provided for Prescription Drugs
Insertion or removal; exam		Not covered at this level	Benefits are available to the same extent as benefits provided for outpatient medical care
<b>Diabetes equipment, supplies, and self-management training</b>		Not covered at this level	80% of Allowed Benefit

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Emergency Services</b>			
Outpatient hospital/physician Emergency Services/urgent care (initial treatment) within 72 hours of accident and trauma		100% of Allowed Benefit	Not covered at this level
Outpatient hospital/physician Emergency Services/urgent care after 72 hours of accident and trauma		Not covered at this level	80% of Allowed Benefit
Outpatient hospital Emergency Services/urgent care for condition other than accident and trauma		Not covered at this level	80% of Allowed Benefit
Outpatient physician Emergency Services/urgent care for condition other than accident and trauma		Not covered at this level	80% of Allowed Benefit
Follow-up care	Limited to two visits within 180 days of accident and trauma	100% of Allowed Benefit	Not covered at this level
Follow-up care		Not covered at this level	80% of Allowed Benefit

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Emergency Services</b>			
Ambulance services	Services are limited to licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance.	Not covered at this level	80% of Allowed Benefit

Covered Service	Limitations	CareFirst Payment
<b>General anesthesia and associated hospital or ambulatory surgical facility services for dental care</b>		Benefits are available to the same extent as benefits provided for other illnesses

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Habilitative Services</b>	An approved Plan of Treatment is required.	Not covered at this level	80% of Allowed Benefit

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Home Health Care</b>	An approved Plan of Treatment is required. Hospital/Home health agency: 90 days of unlimited Home Health Care Visits. Home health aid limited to 40 Home Health Care Visits.	100% of Allowed Benefit	80% of Allowed Benefit for Covered Services in excess of Limitations
Home visits following childbirth		Not covered at this level	No Deductible required 100% of Allowed Benefit
Home visits following the surgical removal of a testicle		Benefits are available to the same extent as benefits provided for other illnesses	
<b>Hospice care</b>	Unlimited days/visits. 1. An approved Plan of Treatment is required; the Plan of Treatment must be accepted in writing by the Member and or family. 2. There must be a willing and able Caregiver available. 3. Respite Care is limited to a maximum of 14 days per year. At the discretion of CareFirst, Respite Care may be limited to five consecutive days for each Inpatient stay. 4. Bereavement counseling is limited to the six month period following the Member's death or 15 visits, whichever occurs first.	100% of Allowed Benefit	Not covered at this level

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

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Inpatient/Outpatient Health Care Provider Services</b>		The CareFirst payment for Members receiving inpatient benefits when this Evidence of Coverage renews will be the benefits in effect at the date of the inpatient admission.	
Inpatient medical care	Inpatient medical care is limited to 120 days per inpatient stay  Renewal interval: an inpatient stay will be one stay if discharge date and readmission date are not separated by at least 90 days	100% of Allowed Benefit	80% of Allowed Benefit for Covered Services in excess of Limitations
Inpatient medical care/Skilled Nursing Care in a Skilled Nursing Facility	Inpatient medical care/Skilled Nursing Care in a Skilled Nursing Facility is limited to 120 days per Benefit Period.	100% of Allowed Benefit	80% of Allowed Benefit for Covered Services in excess of Limitations
Outpatient medical care, consultations		Not covered at this level	80% of Allowed Benefit

CFMI/TRAD wMM SOB (4/05)

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Inpatient/Outpatient Health Care Provider Services</b>		The CareFirst payment for Members receiving inpatient benefits when this Evidence of Coverage renews will be the benefits in effect at the date of the inpatient admission.	
Inpatient hospital services	Inpatient hospital services benefits are limited to 120 days per inpatient stay  Renewal interval: an inpatient stay will be one stay if discharge date and readmission date are not separated by at least 90 days	100% of Allowed Benefit	80% of Allowed Benefit for Covered Services in excess of Limitations
Skilled Nursing Facility services (two days for every one unused hospital day)	Skilled Nursing Facility services are limited to 120 days per Benefit Period.	100% of Allowed Benefit	80% of Allowed Benefit for Covered Services in excess of Limitations
Outpatient hospital and ambulatory surgical facility services		100% of Allowed Benefit	80% of Allowed Benefit
Non Par Providers		80% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Inpatient/Outpatient Health Care Provider Services</b>		The CareFirst payment for Members receiving inpatient benefits when this Evidence of Coverage renews will be the benefits in effect at the date of the inpatient admission.	
Diagnostic services		100% of Allowed Benefit	Not covered at this level
Second surgical opinion		100% of Allowed Benefit	Not covered at this level
Surgery		100% of Allowed Benefit	Not covered at this level
Chemotherapy, radiation therapy, renal dialysis		100% of Allowed Benefit	Not covered at this level
Infusion therapy		Not covered at this level	80% of Allowed Benefit

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Inpatient/Outpatient Health Care Provider Services</b>		The CareFirst payment for Members receiving inpatient benefits when this Evidence of Coverage renews will be the benefits in effect at the date of the inpatient admission.	
Cleft lip or cleft palate, or both			
Orthodontics		Not covered at this level	80% of Allowed Benefit
Oral surgery		Benefits are available to the same extent as benefits provided for other illnesses	
Otological, audiological and speech/language treatment		Not covered at this level	80% of Allowed Benefit
Acupuncture		Not covered at this level	80% of Allowed Benefit
Allergy testing		Not covered at this level	80% of Allowed Benefit
Spinal manipulation		Not covered at this level	80% of Allowed Benefit
Administration of injectable Prescription Drugs by a Health Care Provider		Not covered at this level	80% of Allowed Benefit
Elective sterilization		100% of Allowed Benefit	Not covered at this level

Covered Service	Limitations	CareFirst Payment
<b>Mastectomy—related services</b>		Benefits are available to the same extent as benefits provided for other illnesses

Covered Service	Limitations	CareFirst Payment
<b>Maternity services</b>		Benefits are available to the same extent as benefits provided for other illnesses

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Medical Devices and Supplies</b>			
Durable Medical Equipment		Not covered at this level	80% of Allowed Benefit
Hair prosthesis	Benefits are limited to one hair prosthesis per calendar year.	Not covered at this level	No Deductible required 100% of the Allowed Benefit up to \$350
Hearing Aids		Not covered at this level	No Deductible required 100% of the Allowed Benefit up to \$1,400* every thirty-six (36) months for one Hearing Aid for each hearing-impaired ear * If a Member receives a Hearing Aid that costs more than \$1,400, the Member is responsible for the additional cost, regardless of whether the Health Care Provider is a Participating Provider
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 Low Protein Modified Food Products		Benefits are available to the same extent as benefits provided for Medical Supplies	
Medical Supplies		Not covered at this level	80% of Allowed Benefit
Nutritional substances		Benefits are available to the same extent as benefits provided for Medical Supplies	
Orthotic Devices		Not covered at this level	80% of Allowed Benefit
Prosthetic Devices		100% of Allowed Benefit	80% of Allowed Benefit

Covered Service	Limitations	CareFirst Payment
<b>Organ and tissue transplants: kidney, cornea, bone marrow</b>		Benefits are available to the same extent as benefits provided for other illnesses

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Prescription Drugs</b>		Not covered at this level	80% of Allowed Benefit

Covered Service	Limitations	CareFirst Payment
<b>Surgical treatment of Morbid Obesity</b>		Benefits are available to the same extent as benefits provided for other illnesses

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Treatment of Mental Illnesses, Emotional Disorders, and Drug and Alcohol Abuse</b>			
Inpatient care and Residential Crisis Services		Benefits are available to the same extent as benefits provided for other illnesses	
Halfway House Facility	Halfway House Facility benefits are limited to 60 days per Benefit Period	Not covered at this level	80% of Allowed Benefit
Partial Hospitalization	Partial Hospitalization benefits are limited to 60 days per Benefit Period	Not covered at this level	80% of Allowed Benefit
Outpatient care, including outpatient psychological and neuropsychological testing for diagnostic purposes	An approved Plan of Treatment is required		
Visits 1 through 5 per Benefit Period		Not covered at this level	80% of Allowed Benefit
Visits 6 through 30 per Benefit Period		Not covered at this level	65% of Allowed Benefit
Visits 31 and thereafter per Benefit Period		Not covered at this level	50% of Allowed Benefit
Medication Management		Not covered at this level	80% of Allowed Benefit

Covered Service	CareFirst Payment		
	Blue Cross/ Blue Shield	Major Medical	
		Participating Provider	Non-Participating Provider
Methadone maintenance treatment Note: The Member payment for methadone maintenance treatment will not be greater than 50% of its daily cost	Not covered at this level	No Deductible required 80% of Allowed Benefit	No Deductible required 80% of charge

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
<b>Treatment of Temporomandibular Joint (TMJ) Dysfunction</b>		Not covered at this level	80% of Allowed Benefit

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**CARDIAC REHABILITATION RIDER**

This rider is effective as of the effective date or renewal date of the Evidence of Coverage. Notwithstanding any provision or exclusion to the contrary, the Evidence of Coverage is amended as follows:

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

Benefits will not be provided for maintenance programs.

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

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage. 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	Limitations	CareFirst Payment
Cardiac Rehabilitation	Covered Services are limited to three visits per week for 12 weeks.	80% of Allowed Benefit

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

**CareFirst of Maryland, Inc.**



---

Chester E. Burrell  
President and Chief Executive Officer

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**COMPREHENSIVE PHYSICAL REHABILITATION SERVICES RIDER**

This rider is effective as of the effective date or renewal date of the Evidence of Coverage. Notwithstanding any provision or exclusion to the contrary, the Evidence of Coverage is amended as follows:

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:

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

The following benefits are available for a Member with physical disabilities, such as those as a result of a spinal cord or head injury:

1. Comprehensive Physical Rehabilitation Services provided by a Comprehensive Rehabilitation Facility;
2. Medical care;
3. Diagnostic services;
4. Assistive devices to aid or complement impaired body functions when furnished by the Comprehensive Rehabilitation Facility, including but not limited to wheelchairs, walkerettes, canes, braces;
5. Supplies provided by the Comprehensive Rehabilitation Facility necessary for therapeutic purposes;
6. Prescription Drugs and medicines;
7. for a Member who is an inpatient in a Comprehensive Rehabilitation Facility, bed, board and nursing care in a semi-private room.

The services provided must be billed as regular services by the Comprehensive Rehabilitation Facility and be consistent with the Member's condition.

The Member must experience a better rate of improvement through the Comprehensive Physical Rehabilitation Services of a Comprehensive Rehabilitation Facility than the Member would through a person or hospital which is not a Comprehensive Rehabilitation Facility.

Rehabilitation benefits are limited to the Member's care by the Comprehensive Rehabilitation Facility; some services may be Covered Services under other provisions of the Evidence of Coverage when care is not by a Comprehensive Rehabilitation Facility.

Benefits are not provided for:

1. Vocational Rehabilitative Services.
2. A private room, when the Comprehensive Rehabilitation Facility has semi-private rooms (CareFirst will base payment on the average semi-private room rate).


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. 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	Limitations	CareFirst Payment
Comprehensive Physical Rehabilitative Services: Inpatient	120 days per Benefit Period  Hospital Certification & Review is required for Inpatient Comprehensive Rehabilitation Facility services	100% of Allowed Benefit  Does not contribute to Out-Of-Pocket Maximum
Comprehensive Physical Rehabilitative Services: Outpatient		80% of Allowed Benefit

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

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**OUTPATIENT PRIVATE DUTY NURSING RIDER**

This rider is effective as of the effective date or renewal date of the evidence of coverage. Notwithstanding any provision or exclusion to the contrary, the Evidence of Coverage is amended as follows:

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

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

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

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage. 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.

<b>Covered Service</b>	<b>Limitations</b>	<b>CareFirst Payment</b>
Outpatient Private Duty Nursing	An approved Plan of Treatment is required	80% of Allowed Benefit

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

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**LIVER, HEART, PANCREAS, SINGLE/DOUBLE-LUNG, HEART-LUNG  
ORGAN TRANSPLANTS RIDER**

This rider is effective as of the effective date or renewal date of the Evidence of Coverage. Notwithstanding any provision or exclusion to the contrary, the Evidence of Coverage is amended as follows:

In addition to the definitions contained in the Evidence of Coverage to which this rider is attached, the underlined term, below, when capitalized, has the following meaning:

Related Services means services or supplies for, or related to procedures, including but not limited to: diagnostic services, inpatient/outpatient Health Care Provider services, Prescription Drugs, surgical services, Rehabilitative Services.

Benefits are available for:

1. Human organ transplants: Liver, Heart, Pancreas, Single/Double-Lung, Heart-Lung and Related Services;
2. Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant.
3. Immunosuppressant maintenance drugs when prescribed for a covered transplant.
4. Organ transplant procurement benefits for the recipient:
  - a. Health services and supplies used by the surgical team to remove the donor organ;
  - b. Travel of a hospital surgical team to and from a hospital (other than the organ transplant hospital) where the organ is to be removed from the donor;
  - c. Transport and storage of the organ, at the organ transplant hospital, in accordance with approved practices.
5. Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant hospital is over 50 miles from the recipient's home.

When the recipient is a Member, organ transplant benefits are available for both the recipient and the donor; when only the donor is a Member, organ transplant benefits are available for the donor only, and then only if the recipient has no benefits available for the donor.

The organ transplant hospital must:

1. Have fair and practical rules for choosing recipients;
2. Have a written contract with someone that has the legal right to procure donor organs;
3. Conform to all laws that apply to organ transplants;
4. Be approved by CareFirst.

At least 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;
4. Prescribed treatment.

Travel is limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. In order to receive travel benefits, a companion must be at least 18 years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under 18, there may be two companions.

Organ transplant benefit period: the period starting five days immediately before the date the organ transplant is performed and continuing for 365 days.

For canceled or postponed organ transplants, the organ transplant benefit period for all Covered Services is that period starting five days immediately before the organ transplant is scheduled to be performed and continuing for 45 consecutive days or until discharge; whichever comes first.

Once the Member is discharged, or the 45 days are exhausted, benefits are available to the extent of the Member's regular medical-surgical benefits Evidence of Coverage. Should the Member be subsequently re-admitted and organ transplant surgery completed, a new 365-day organ transplant benefit period begins.

Benefits are not provided for:

1. Any and all services for or related to any organ transplants except those specifically stated in the Description of Covered Services and this rider.
2. Services or supplies not shown in the Description of Covered Services and this rider as a Covered Service, including services or supplies for, or related to surgical organ transplant procedures not specifically listed as covered;
3. Any organ transplant or procurement done outside the continental United States;
4. An organ transplant relating to a condition arising from and in the course of employment;
5. Organ transplant Covered Services if there are research funds to pay for the Covered Services;
6. Expenses Incurred for the location of a suitable donor, e.g., National Bone Marrow Registry, search of a population or mass screening;
7. Services or supplies for or related to organ transplants under this Evidence of Coverage while benefits are being paid under this rider during the organ transplant benefit period. All directly Related Services are also excluded under the Evidence of Coverage.

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. 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
Organ Transplants: Liver, Heart, Pancreas, Single/Double-Lung, Heart-Lung	No Deductible required 100% of Allowed Benefit
Organ Transplant procurement	No Deductible required 100% of Allowed Benefit
Organ Transplant travel	No Deductible required 100% of charges \$150 per day up to \$10,000 maximum

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

**CareFirst of Maryland, Inc.**




---

Chester E. Burrell  
President and Chief Executive Officer

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**REHABILITATIVE SERVICES RIDER**

This rider is effective as of the effective date or renewal date of the Evidence of Coverage. Notwithstanding any provision or exclusion to the contrary, the Evidence of Coverage is amended as follows:

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

CareFirst pays only for Covered Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible, 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 and limitations in the Evidence of Coverage as well as its medical policies. When these conditions of coverage are not met or followed, payments for benefits may be denied.

Certain Utilization Management Requirements may also apply. When these requirements are not met, payments may be denied or reduced. See Utilization Management Requirements for these requirements.

Covered Service	CareFirst Payment	
	Blue Cross/Blue Shield	Major Medical
<b>Rehabilitative Services</b>	Limitations 100 Blue Cross/Blue Shield visit limit per Benefit Period: Physical Therapy	
Occupational Therapy	Not covered at this level	80% of Allowed Benefit
Physical Therapy	100% of Allowed Benefit; thereafter	80% of Allowed Benefit
Speech Therapy	Not covered at this level	80% of Allowed Benefit

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

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**PRESCRIPTION DRUG BENEFITS RIDER**

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

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<b>SECTION A</b>	<b>DEFINITIONS</b>
<b>SECTION B</b>	<b>DESCRIPTION OF COVERED SERVICES</b>
<b>SECTION C</b>	<b>EXCLUSIONS</b>
<b>SECTION D</b>	<b>SCHEDULE OF BENEFITS</b>

**SECTION A DEFINITIONS**

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

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

1. The Pharmacy's actual charge; or
2. The benefit amount, according to the CareFirst fee schedule, for Prescription Drug Covered Service that applies on the date that the service is rendered.

Contracting Pharmacy: If the Member purchases a Prescription Drug Covered Service or Diabetic Supply from a Contracting Pharmacy, the benefit payment is made directly to the Contracting Pharmacy and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.

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

Brand Name Drug means a Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and that may be used and protected by a trademark.

Contracting Pharmacy means the separate independent Pharmacist or Pharmacy that has contracted with CareFirst or its designee to be paid directly for a Prescription Drug Covered Service.

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

Diabetic Supplies means all appropriate supplies prescribed by a Health Care Provider for the treatment of diabetes.

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

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

Nicotine Replacement Therapy means a product that:

1. Is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and
2. Is approved by the FDA as an aid for the cessation of the use of tobacco products; and
3. Is obtained under a prescription written by an authorized prescriber.

Nicotine Replacement Therapy does not include any Over-the-Counter product that may be obtained without a prescription.

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

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

Pharmacist means an individual who practices Pharmacy regardless of the location where the activities of practice are performed.

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

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

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

### **Medical Necessity**

CareFirst will provide a benefit for RetinA for a Member 35 years and over when Medically Necessary as determined by CareFirst. Benefits are subject to all of the terms, conditions, and maximums, if applicable, as stated herein.

Claims for Prescription Drug Benefits must be submitted within twelve (12) months following the dates services were rendered.

## **SECTION B DESCRIPTION OF COVERED SERVICES**

Benefits are available via retail or mail order for:

1. Up to a 34-day supply of a Prescription Drug.
2. Up to a 90-day supply of a Maintenance Drug.
3. Insulin, insulin syringes, and other Diabetic Supplies.
4. Nicotine Replacement Therapy.
5. Prescription Drug vitamins, limited to:
  - a. Prenatal vitamins;
  - b. Fluoride and fluoride-containing vitamins;
  - c. Single entity vitamins, such as Rocaltrol and DHT.
6. Prescription Drugs approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider:
  - a. Up to a three-month supply of oral, transdermal, and combination-hormone vaginal ring contraceptives.
  - b. Up to a 90-day supply of non-surgical, injectable contraceptives.
  - c. Contraceptive devices limited to: cervical cap, diaphragm.

The insertion or removal, and any Medically Necessary examination associated with the use of such contraceptive drug or device is a Covered Service under the medical portion of the Evidence of Coverage.

## **SECTION C EXCLUSIONS**

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

Benefits are not provided for:

- Prescription Drugs administered or dispensed by a health care facility for a Member who is a patient in the health care facility. This exclusion does not apply to Prescription Drugs that are dispensed by a Pharmacy on the health care facility's premises for a Member who is not an inpatient in the health care facility.
- Prescription Drugs for cosmetic use.
- Prescription Drugs for weight loss.
- Prescription Drug vitamins, except as listed herein.
- Prescription Drugs administered or dispensed in a Health Care Provider's office except allergy sera (serum).
- Contraceptives requiring surgical injection, and contraceptive devices except as listed herein.

**SECTION D SCHEDULE OF BENEFITS**

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

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

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

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

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

<b>Important note regarding CareFirst/Member Payments</b>
If the cost of the Prescription Drug is less than the Member payment, then the cost of the Prescription Drug will be payable by the Member at the time the prescription is filled.
A Member may select a Prescription Drug that is not included on the Preferred Drug List. If a Member selects a Brand Name Drug when a Generic Drug is available, the Member payment will be that for a Non-Preferred Brand Name Drug.

Covered Service	CareFirst Payment	Member Payment	
		Prescription Drug	Maintenance Drug
Generic Drug	100% of Allowed Benefit after Member payment	\$10 Copay	The Member pays one Copay for up to a 34-day supply plus a second Copay for a supply of 35-days or more
Preferred Brand Name Drug		\$10 Copay	
Non-Preferred Brand Name Drug		\$20 Copay	
Insulin syringes and other Diabetic Supplies		Copay waived	

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

**CareFirst of Maryland, Inc.**



\_\_\_\_\_  
 Chester E. Burrell  
 President and Chief Executive Officer

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**RESIDENTIAL CRISIS SERVICES AMENDMENT**

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

The definition of Residential Crisis Services in the Description of Covered Services is deleted and replaced with the following:

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

1. Provided to a Dependent child or an adult Member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the ability of the Member to function in the community; and
2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency departments; and
3. Provided by entities that are licensed by the State of Maryland Department of Health and Mental Hygiene or the applicable licensing laws of any State or the District of Columbia to provide Residential Crisis Services; or
4. Located in subacute beds in an inpatient psychiatric facility, for an adult Member.

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

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---

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**REFERRAL TO A SPECIALIST OR NONPHYSICIAN SPECIALIST AMENDMENT**

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

The Section entitled **Referral to a Specialist** within **HOW THE PLAN WORKS** is deleted and replaced with the following:

**Referral to a Specialist or Nonphysician Specialist**

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

A Nonphysician Specialist is a Health Care Provider who:

1. Is not a physician;
2. Is licensed or certified under the Health Occupations Article of the Annotated Code of Maryland or the applicable licensing laws of any State or the District of Columbia; and
3. Is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.

A Member may request a referral to a Specialist or Nonphysician Specialist who is a Non-Preferred Provider if:

The Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and

1. CareFirst does not contract with a Preferred Specialist or Nonphysician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or
2. CareFirst cannot provide reasonable access to a Preferred Specialist or Nonphysician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

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

A decision by CareFirst not to provide access to or coverage of treatment or health care services by a Specialist or Nonphysician Specialist within this section constitutes an Adverse Decision as defined in the Evidence of Coverage if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

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

**CareFirst of Maryland, Inc.**

A handwritten signature in cursive script that reads "Chester E. Burrell".

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Chester E. Burrell  
President and Chief Executive Officer

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**TERMINATION OF COVERAGE AMENDMENT**

This amendment is effective as of the effective date of the Evidence of Coverage. Notwithstanding any provision or exclusion to the contrary, the Evidence of Coverage is amended as follows:

Section 4.1.E. entitled **Disenrollment of Individual Members** within **TERMINATION OF COVERAGE** is deleted and replaced with the following:

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

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**MEDICALLY NECESSARY AMENDMENT**

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

The definition of "Medically Necessary or Medical Necessity" in the Evidence of Coverage is deleted and replaced with the following:

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

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;
3. not primarily for the convenience of a patient or Health Care Provider; and
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury, or disease.

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

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

**CareFirst of Maryland, Inc.**



---

Chester E. Burrell  
President and Chief Executive Officer

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

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

An independent licensee of the Blue Cross and Blue Shield Association

**OCTOBER 2008 AMENDMENT**

This amendment is effective on the effective date of the Group Contract and Evidence of Coverage to which this amendment is attached.

The Evidence of Coverage is amended as follows:

Amino Acid-Based Elemental Formulas. Coverage for Medically Necessary amino acid-based elemental formulas, regardless of delivery method, will be provided for the diagnosis and treatment of:

1. Immunoglobulin-E and non-immunoglobulin-E mediated allergies to multiple food proteins;
2. Severe food protein induced enterocolitis syndrome;
3. Eosinophilic disorders, as evidenced by biopsy; and
4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Benefits are available to the same extent as benefits provided for Medical Supplies.

Benefits will not be provided for amino acid-based elemental formulas for diagnoses not listed in this amendment.

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

**CareFirst of Maryland, Inc.**



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**SPECIAL ENROLLMENT PERIODS AMENDMENT**

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

The following is added to the Eligibility and Enrollment section, 2.6 Enrollment Opportunities and Effective Dates, C. Special Enrollment Periods:

c. Special enrollment regarding Medicaid and 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) 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) 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).

The following is added to the Eligibility Schedule section, SPECIAL ENROLLMENT PERIODS:

<b>SPECIAL ENROLLMENT PERIODS</b>	
Special enrollment regarding Medicaid and CHIP termination or eligibility	<p>The employee must notify the Group, and the Group must notify CareFirst no later than 60 days after the date the employee or dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act</p> <p>The employee must notify the Group, and the Group must notify CareFirst no later than 60 days after the date the employee or dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan)</p> <p>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</p>

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

**CareFirst of Maryland, Inc.**

A handwritten signature in cursive script that reads "Chester E. Burrell".

---

Chester E. Burrell  
President and Chief Executive Officer

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**MENTAL HEALTH AND SUBSTANCE ABUSE PARITY AMENDMENT**

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

The Schedule of Benefits below replaces the services listed in the Schedule of Benefits attached to the Evidence of Coverage. CareFirst's payment for the treatment of mental illnesses, emotional disorders and drug and alcohol abuse is:

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
Treatment of Mental Illnesses, Emotional Disorders, and Drug and Alcohol Abuse			
Inpatient care and Residential Crisis Services		Benefits are available to the same extent as benefits provided for treatment of other illnesses	Benefits are available to the same extent as benefits provided for treatment of other illnesses
Halfway House Facility	Number of visits not limited	Not covered at this level	Benefits are available to the same extent as benefits provided for treatment of other illnesses
Partial Hospitalization	Number of visits not limited	Not covered at this level	Benefits are available to the same extent as benefits provided for treatment of other illnesses
Outpatient care, including office visits and outpatient psychological and neuropsychological testing for diagnostic purposes	Number of visits not limited	Not covered at this level	Benefits are available to the same extent as benefits provided for treatment of other office services for treatment of other illnesses

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
Medication Management	Number of visits not limited	Not covered at this level	Benefits are available to the same extent as benefits provided for treatment of other illnesses
Methadone maintenance treatment	Number of visits not limited	Not covered at this level	No Deductible required 100% of the Allowed Benefit

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

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**OCTOBER 2009 AMENDMENT REVISED**

The Evidence of Coverage is amended as follows:

- SECTION A – BREAST CANCER SCREENING**  
**SECTION B – HOSPITALIZATION AND HOME VISITS FOLLOWING MASTECTOMY**  
**SECTION C – COVERAGE OF ORTHOTIC DEVICES, PROSTHETIC DEVICES**

**SECTION A – BREAST CANCER SCREENING**

I. Description of Covered Services, Preventive Care, Mammography Screening is deleted and replaced with the following:

**Breast Cancer Screening**

1. Covered Services  
 Benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.
2. Benefits for breast cancer screening are not subject to the Deductible, if any.

II. Schedule of Benefits, Mammography Screening, is deleted and replaced with the following:

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/Blue Shield	Major Medical
Breast Cancer Screening		No Deductible required Benefits are available to the same extent as benefits provided for diagnostic services	

## **SECTION B – HOSPITALIZATION AND HOME VISITS FOLLOWING MASTECTOMY**

- I. Definitions is amended to add the following:
- Mastectomy means the surgical removal of all or part of a breast.
- II. Description of Covered Services, Mastectomy – Related Services, Item 1 deleted and replaced with the following:
1. Reconstructive breast surgery means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts.
    - a. Reconstructive breast surgery includes:
      - a. Augmentation mammoplasty;
      - b. Reduction mammoplasty; and
      - c. Mastopexy.
    - b. Benefits are provided for all stages of reconstructive breast surgery performed on the non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery on the diseased breast is performed.
- III. Description of Covered Services, Mastectomy – Related Services, Item 3 is deleted and replaced with the following:
3. Coverage will be provided for treatment of physical complications at all stages of Mastectomy, including lymphedemas, in a manner determined in consultation with the Member and the Member's attending physician.
- IV. Description of Covered Services, Mastectomy – Related Services, Item 4 is deleted and replaced with the following:
4. Inpatient Coverage Following a Mastectomy.  
Coverage will be provided for a minimum hospital stay of not less than forty-eight (48) hours following a Mastectomy.  
  
In consultation with the Health Care Practitioner, the Member may elect to stay less than the minimum prescribed above when appropriate.
  5. Home Visits Following a Mastectomy.
    - a. For a Member who has a shorter hospital stay than that provided under the provision concerning inpatient coverage following a Mastectomy or who undergoes a Mastectomy on an outpatient basis, benefits will be provided for:
      - i. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and
      - ii. An additional home visit if prescribed by the Member's attending physician.
    - b. For a Member who remains in the hospital for at least the length of time provided under the provision concerning inpatient coverage following a Mastectomy, coverage will be provided for a home visit of prescribed by the Member's attending physician.

## **SECTION C – COVERAGE OF ORTHOTIC DEVICES, PROSTHETIC DEVICES**

- I. Description of Covered Services, Medical Devices and Supplies, Orthotic Devices, Prosthetic Devices is deleted and replaced with the following:

### **Orthotic Devices, Prosthetic Devices**

1. Except for a prosthetic leg, arm or eye, benefits provided for Orthotic Devices and Prosthetic Devices include:
  - a. Supplies and accessories necessary for effective functioning of Covered Service;
  - b. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and
  - c. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.
2. Prosthetic Leg, Arm or Eye
  - a. Covered Benefits.  
Coverage shall be provided for an artificial device which replaces, in whole or in part, a leg, an arm or an eye.
  - b. Coverage includes:
    - i. Components of prosthetic leg, arm or eye; and
    - ii. Repairs to prosthetic leg, arm or eye.
  - c. Benefits for prosthetic legs, arms or eyes do not accrue to the annual benefit maximum, if any, for medical devices and supplies.
  - d. Benefits for prosthetic legs, arms or eyes are available to the same extent as benefits provided for office visits for medical treatment.
  - e. Requirements for Medical Necessity for coverage of a prosthetic leg, arm or eye will not be more restrictive than the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.
  - f. Prior authorization is not required for benefits for prosthetic legs, arms or eyes.

This amendment is issued to attach to the Evidence of Coverage. This amendment does not change the terms and conditions of the Evidence of Coverage, unless specifically stated herein.

**CareFirst of Maryland, Inc.**



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President and Chief Executive Officer

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**OCTOBER 2010 AMENDMENT**

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

The Evidence of Coverage is amended as follows:

- I. Description of Covered Services, Preventive Services, Child Wellness is deleted and replaced with the following:
  - A. Child Wellness. Well child preventive care and pediatric services in accordance with the most recent guidelines of the American Academy of Pediatrics including:
    1. Each office visit in which a childhood or adolescent immunization, recommended by the Advisory Committee on Immunizations Practices of the Center for Disease Control, is administered, and the cost of the immunization.
    2. Visits for the collection of adequate samples for hereditary and metabolic newborn screening and follow-up between birth and four (4) weeks of age, the first of which is to be collected before two (2) weeks of age.
    3. Universal hearing screening of newborns provided by a hospital before discharge, or in an office or other outpatient setting.
    4. Visits for and costs of age appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics.
    5. Visits for obesity evaluation and management.
    6. Visits for and cost of developmental screening as recommended by the American Academy of Pediatrics.
    7. Examinations including developmental assessments and parental anticipatory guidance.
    8. Laboratory tests necessary to provide these services.
- II. Description of Covered Services, Exclusions, 18<sup>th</sup> bullet is deleted and replaced with the following:
  - Medical or surgical treatment for obesity, weight reduction or dietary control. This exclusion does not apply to surgical procedures for the treatment of Morbid Obesity and well child care visits for obesity evaluation and management.

- III. Description of Covered Services, Preventive Care, Text Box is deleted and replaced with the following:

In addition to the benefits listed below, CareFirst will provide additional 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 CareFirst preventive guidelines. At a minimum, benefits for preventive services listed will be provided once per Benefit Period.

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

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**EXPANSION OF DEPENDENT COVERAGE AMENDMENT**

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

**TABLE OF CONTENTS**

**SECTION A – ELIGIBILITY**

**SECTION B – TERMINATION**

**SECTION C – DEFINITION OF DEPENDENT CHILD**

**SECTION D - TRANSITION FOR DEPENDENT CHILDREN PREVIOUSLY DENIED  
ENROLLMENT OR WHO TERMINATED COVERAGE DUE TO ATTAINING  
LIMITING AGE**

The Evidence of Coverage is amended as follows:

A. **ELIGIBILITY**

All provisions of the Evidence of Coverage that state that a Dependent child's eligibility for coverage is based on any factor other than the relationship between the Dependent child and an individual covered under the Evidence of Coverage are deleted. All requirements that the Dependent child, prior to his or her 26<sup>th</sup> birthday, be financially dependent on an individual covered under the Evidence of Coverage, that the Dependent child share a residence with an individual covered under the Evidence of Coverage, that the Dependent child meet certain student status requirements, that the Dependent child be unmarried, that the Dependent child not be eligible for other coverage, or that the Dependent child not be employed, are deleted. Nothing in this amendment should be construed to amend any requirement related to the eligibility of a Dependent child over the age of 26.

B. **TERMINATION**

All provisions of the Evidence of Coverage that state that a Dependent child's coverage will terminate when the Dependent child marries, ceases to be financially dependent on an individual covered under the Evidence of Coverage, ceases to share a residence with an individual covered under the Evidence of Coverage, ceases to be a full-time or part-time student, is eligible for other coverage, becomes employed full-time or part-time, or reaches the Dependent child's 25th birthday are deleted.

The Evidence of Coverage is amended to provide that the coverage of a Dependent child will terminate on the date the Dependent child reaches his or her 26th birthday or the age stated in the Eligibility Schedule, whichever is greater. The Limiting Age will not apply to a Dependent child, who at the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age, provided the incapacitated Dependent child is unmarried and dependent on an individual covered under the Evidence of Coverage. Coverage of the incapacitated Dependent child will continue for as long as the Dependent child remains incapable of self-support because of a mental or physical incapacity, unmarried, and dependent on an individual covered under the Evidence of Coverage.

C. DEFINITION OF DEPENDENT CHILD

All provisions of the Evidence of Coverage that define or describe the eligibility of a Dependent for coverage under the Evidence of Coverage are revised to include a Dependent child who has not attained his or her 26th birthday notwithstanding the Dependent child's:

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


D. TRANSITION FOR DEPENDENT CHILDREN PREVIOUSLY DENIED ENROLLMENT OR WHO TERMINATED COVERAGE DUE TO ATTAINING LIMITING AGE

The Evidence of Coverage is amended to provide coverage from the first day of the first benefit period occurring on or after September 23, 2010, if the Dependent child meets both of the following:

1. The Dependent child was terminated from coverage previously due to failure to satisfy the Dependent child definition of the Evidence of Coverage or the Dependent child was prohibited from enrolling under the Evidence of Coverage due to failure to meet the Dependent child definition in the Evidence of Coverage and
2. The Dependent child enrolls during the first 30 days of the first benefit period occurring on or after September 23, 2010.

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

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---

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**PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT**

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

**TABLE OF CONTENTS**

**SECTION A – DEFINITIONS**  
**SECTION B – LIFETIME MAXIMUM**  
**SECTION C – ANNUAL DOLLAR LIMITS**  
**SECTION D – RESCISSIONS**

The Evidence of Coverage is amended as follows:

**A. Definitions**

The following definitions have the following meaning in this amendment:

Essential Health Benefits has the meaning found in section 1302 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 abuse 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.

**B. Lifetime Maximum**

Any lifetime maximum on any Essential Health Benefit in the Evidence of Coverage is deleted. The lifetime maximum on in vitro fertilization shall not be affected by this amendment.

The Evidence of Coverage is amended to provide that, if a Member's coverage under the Evidence of Coverage had terminated due to reaching a lifetime maximum, the Member may enroll during the first 30 days of a Benefit Period that begins on or after September 23, 2010, and coverage will begin on the first day of the Benefit Period that begins on or after September 23, 2010.

**C. Annual Dollar Limits**

Any annual dollar limit on Essential Health Benefits in the Evidence of Coverage is deleted. The annual dollar limitation on hair prostheses shall not be affected by this amendment.

**D. Rescissions**

Any provision of the Evidence of Coverage that describes the right of CareFirst to rescind or void the Evidence of Coverage is amended to permit CareFirst to rescind or void the coverage of a group or Member only if (1) the group or Member performs an act, practice, or omission that constitutes fraud; or (2) the group or Member makes an intentional misrepresentation of material fact.

Any provision of the Evidence of Coverage that provides for a notice of rescission of coverage and that provides less than 30-days advance written notice of any rescission of coverage is amended to provide 30-days advance written notice of any rescission of coverage.

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

**CareFirst of Maryland, Inc.**



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**PRIMARY CARE MEDICAL HOME PROGRAM AMENDMENT**

The Evidence of Coverage is amended as follows:

I. Definitions, is amended to add the following:

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, as used in this amendment, means a physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services described in this amendment.

Primary Care Medical Home Program ("PCMH") means medical and associated services directed by the PCMH team of medical professionals to:

- A. Foster the Health Care Provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;
- B. Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and,
- C. Exchange medical information with CareFirst, other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.

Qualifying Individual 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 Primary Care Medical Home Program.

II. Description of Covered Services is amended to add the following:

Primary Care Medical Home Program. Benefits will be provided for:

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

III. Schedule of Benefits is amended to add the following:

Covered Service	Limitations	CareFirst Payment	
		Blue Cross/ Blue Shield	Major Medical
Primary Care Medical Home	Benefits provided through the Primary Care Medical Home Program are available only when provided by a CareFirst-approved Health Care Provider who has elected to participate in the CareFirst Primary Care Medical Home Program.	No Deductible required 100% of the Allowed Benefit	

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

**CareFirst of Maryland, Inc.**




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**ASSIGNMENT OF BENEFITS AND ALLOWED BENEFIT AMENDMENT**

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

The Evidence of Coverage is amended as follows:

**TABLE OF CONTENTS**

**SECTION A    DEFINITIONS**  
**SECTION B    ASSIGNMENT OF BENEFITS**  
**SECTION C    RELATED PROVISIONS**

**SECTION A    DEFINITIONS**

The definition of Allowed Benefit in the Evidence of Coverage is deleted and replaced with the following:

Allowed Benefit means:

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

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

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

**For a Hospital-Based Physician:** No less than the greater of:

- (a) 140% of the average rate the insurer paid for the 12 month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to similarly licensed providers, who are Hospital-Based Physicians under written contract with CareFirst; or
- (b) The final allowed amount of CareFirst for the same Covered Service for the 12-month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the Hospital-Based Physician billing under the same federal tax identification number the Hospital-Based Physician used in calendar year 2009.

**For an On-Call Physician:** No less than the greater of:

- (a) 140% of the average rate the insurer paid for the 12 month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to similarly licensed providers under written contract with CareFirst; or
- (b) The average rate CareFirst paid for the 12-months period that ended on January 1, 2010, in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Service to a similarly licensed provider not under written contract with CareFirst inflated by the change in the Medicare Economic Index from 2010 to the current year.

The benefit is payable to the On-Call Physician or Hospital-Based Physician and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.

2. **For a Covered Service rendered by any other Non-Preferred Provider:** The Allowed Benefit for a Covered Service is no less than the allowed amount paid to a similarly licensed provider who is a Preferred Provider for the same health care service in the same geographic region. For a Non-Preferred Provider who is a physician, the benefit is payable to the physician if the Member has given an Assignment of Benefits or, otherwise, to the Member or the physician at the discretion of CareFirst. For any other Non-Preferred Provider who is a health care practitioner, the benefit is payable to the Member or to the Non-Preferred Provider at the discretion of CareFirst. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Provider. In any event, the Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for any Balance Bill.

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

The following definitions are added to the Evidence of Coverage:

Assignment of Benefits means the transfer of health care coverage reimbursement benefits or other rights under the [Evidence; Certificate] of Coverage by, or on behalf of, the Member to a physician, a Hospital-Based Physician, or an On-Call Physician pursuant to Annotated Code of Maryland, Insurance Article §14-205.2 or §14-205.3.

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

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.

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.

## **SECTION B ASSIGNMENT OF BENEFITS**

“Assignment of Benefits” in the How the Plan Works section of the Evidence of Coverage is deleted and replaced with the following:

### **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 or an On-Call Physician; 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.

## **C. RELATED PROVISIONS**

The section entitled “Non-Participating Providers” in the document entitled “How the Plan Works” is deleted and replaced with the following:

### Non-Participating Providers

1. Claims may be submitted directly to CareFirst or its designee by the Health Care Provider, or the Member may need to submit the claim. In either case, it is the responsibility of the Member to make sure that proofs of loss are filed on time.
2. All benefits for Covered Services rendered by a Non-Participating Provider other than an On-Call Physician, a Hospital Based Physician and any other physician who accepts an Assignment of Benefits will be payable to the Subscriber, or to the Health Care Provider, at the discretion of CareFirst.

3. In the case of a Dependent child enrolled pursuant to a court order, court approved requirement, or a Qualified Medical Child Support Order, payment will be paid directly to the Department of Health and Mental Hygiene or the noninsuring parent if proof is provided that such parent has paid the Health Care Provider.
4. Except for Covered Services rendered by an On-Call Physician or a Hospital Based Physician who accepts an Assignment of Benefits, the Member is responsible for the difference between CareFirst's payment and the Non-Participating Provider's charge.

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

**CareFirst of Maryland, Inc.**



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Chester E. Burrell  
President and Chief Executive Officer

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

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

An independent licensee of the BlueCross and BlueShield Association

**BENEFIT DETERMINATION AND  
APPEAL AND GRIEVANCE PROCEDURES**

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

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

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

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## A. DEFINITIONS

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

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

Adverse Decision means a utilization review determination that:

1. A proposed or delivered health care service covered under the Member's contract is or was not Medically Necessary, appropriate, or efficient; and
2. May result in non-coverage of the health care service. Adverse Decision does not include a Coverage Decision.

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

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

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

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

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

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

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

Coverage Decision means:

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

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

A Coverage Decision does not include an Adverse Decision or a Pharmacy Inquiry.

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

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

Filing Date means the earlier of:

1. 5 days after the date of mailing; or
2. The date of receipt.

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

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

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 Employee Retirement and Income Security Act ("ERISA" or "Act").

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

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

1. An individual who is licensed under the Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the Member; or
2. A hospital as defined in Title 19 Subtitle 3 of the Health-General Article.

Member, as used in this attachment, means an individual entitled to receive health care benefits under this Evidence of Coverage.

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

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

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

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst e is the carrier under the Evidence of Coverage.

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

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

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

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

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

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

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

1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
  - a. Placing the member's life or health in serious jeopardy;
  - b. The inability of the member to regain maximum function;
  - c. Serious impairment to bodily function;
  - d. Serious dysfunction of any bodily organ or part; or
  - e. The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or
2. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

## **B. SCOPE**

The Plan's Claims Procedures were developed in accordance with Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims For Benefits by Members.

## **C. CLAIMS PROCEDURES**

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

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

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

## **D. CLAIMS PROCEDURES COMPLIANCE**

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

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

- a. Is a communication by a Member, the Member's Representative, or Health Care Provider acting on behalf of the Member that is received by the person or organizational unit designated by the Plan or Plan Designee that handles Claims for Benefits; and
  - b. Is a communication that names a specific Member; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.
2. Civil Action. A Member is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA.

## **E. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS**

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

2. The Member shall be notified of the determination in accordance with the following, as appropriate.
  - a. Expedited Notification of benefit determinations relating to Claims Involving Urgent Care. In the case of a Claim Involving Urgent Care, the Member shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim unless the Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Member shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Member shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Member shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:
    - i. Receipt of the specified information, or
    - ii. The end of the period afforded the Member to provide the specified additional information.
  - b. Concurrent care decisions. If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:
    - i. Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Member shall be notified in accordance with paragraph E.2.e herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.
    - ii. Any request by a Member to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Member shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and an Appeal shall be governed by paragraphs G.2, G.3 and G.4 herein as appropriate.
    - iii. If a health care service for a Member has been preauthorized or approved by the Plan or the Plan's Designee, the Plan may not deny reimbursement to the Health Care Provider for the preauthorized or approved service delivered to the Member unless:
      - 1) The information submitted regarding the service was fraudulent or intentionally misrepresentative;
      - 2) Critical information required by the Plan or the Plan's Designee was omitted such that the Plan or Plan Designee's determination would have been different had it known the critical information;
      - 3) A planned course of treatment for the Member was not substantially followed by the Health Care Provider; or

- 4) On the date the preauthorized service was delivered:
  - a) the Member was not covered by the Plan;
  - b) the Plan or the Plan's Designee maintained an automated eligibility verification system that was available to the Provider by telephone or via the Internet; and
  - c) according to the verification system, the Claimant was not covered by the Plan.
- iv. Continued coverage will be provided pending the outcome of an appeal.
- c. Other claims for health care benefits. In the case of a claim that is not an urgent care claim or a concurrent care decision the Member shall be notified of the benefit determination in accordance with the below "Pre-Service Claims" or "Post-Service Claims," as appropriate.
  - i. Pre-Service Claims. In the case of a Pre-Service Claim, the Member shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control, and notifies the Member, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph G. herein.

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

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

clean and the specific additional information necessary for the claim to be considered a clean claim. The Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

- d. Rescission determinations. The Plan shall provide 30-days advance written Notice of any proposed Rescission of coverage for any individual.
- e. Calculating time periods. For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2 above due to a Member's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information.

**F. MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS**

- 1. This section sets forth the manner and content of Notifications by the Plan of Adverse Benefit Determinations.
- 2. In the case of an Adverse Decision, the Plan or the Plan's Designee shall send a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with written or electronic Notification of any Adverse Benefit Determination. In the case of an Adverse Decision relating a Claim for Benefits that is not a Claim Involving Urgent Care, the Plan or the Plan's Designee shall send the written or electronic Notification within 5 working days after the Adverse Decision has been made. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider:
  - a. The identity of the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
  - b. The specific reason or reasons for the Adverse Decision;
  - c. Reference to the specific Plan provisions on which the Adverse Decision is based;
  - d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;
  - e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following an Adverse Decision;
  - f. The Medical Director's name, business address and business telephone number;
  - g. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Decision, 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 Decision and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Member upon request; or

- h. If the Adverse Decision is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances.
  - i. In the case of an Adverse Decision by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.
  - j. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Grievance Decision;
  - k. That a Complaint may be filed without first filing a Grievance if
    - i. The Plan notifies the Member in writing that it has waived the requirement that its internal grievance process be exhausted before filing a Complaint with the Commissioner;
    - ii. The Plan has failed to comply with any of the requirements of the internal grievance procedure described in this attachment; or
    - iii. the Member, the Member's Representative or Health Care Provider acting on behalf of the Member filing a Grievance on behalf of the Member can demonstrate a Compelling Reason to do so as determined by the Commissioner;
  - l. The Commissioner's address, telephone number, and facsimile number;
  - m. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance; and
  - n. The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.
3. In the case of a Coverage Decision, the Plan or the Plan Designee must within 30 calendar days provide Member, Member's Representative and the treating Health Care Provider, a written Notice of the Coverage Decision. The statement must state in detail, in clear, understandable language, the specific factual bases for the Plan's decision and must include the following information:
- a. Where applicable, the identity of the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
  - b. The specific reason or reasons for the Coverage Decision;
  - c. Reference to the specific Plan provisions on which the Coverage Decision is based;
  - d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

- e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following a Coverage Decision;
  - f. The Medical Director's name, business address and business telephone number;
  - g. That the Member, Member's Representative or Health Care Provider acting on behalf of the Member has a right to file an Appeal with the Plan or the Plan's Designee;
  - h. In the case of a Coverage Decision by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.
  - i. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Appeal Decision;
  - j. That the Member, Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves a Claim Involving Urgent Care which has not been rendered;
  - k. The Commissioner's address, telephone number, and facsimile number;
  - l. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing an Appeal; and
  - m. The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.
4. Adverse Benefit Determinations are made under the direction of the Medical Director.

**G. APPEALS AND GRIEVANCES OF ADVERSE BENEFIT DETERMINATIONS**

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

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

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

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

- b. A Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Member's Claim for Benefits;
  - c. The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
3. In addition to the requirements of paragraphs G.2.a through c herein, the following apply:
- a. The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an individual who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor the subordinate of such individual;
  - b. In deciding a Grievance of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/Investigational, or not Medically Necessary or appropriate, the Plan or the Plan's Designee shall consult with a Health Care Provider with the same specialty as the treatment under review.
  - c. Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Member's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
  - d. Health Care Provider engaged for purposes of a consultation under paragraph H.3.b herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor subordinates of any such individuals; and
  - e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal or Grievance of an Adverse Benefit Determination may be submitted orally or in writing by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member; and the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its determination in writing within 24 hours of receipt of the expedited request for Appeal or Grievance.
4. Full and fair review. The Plan or the Plan's Designee shall allow a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to review the claim file and to present evidence and written testimony as part of the internal claims and Appeals or Grievances process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:
- a. The Plan or the Plan's Designee shall provide the Member, the Member's Representative or Health Care Provider acting on behalf of the Member, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Grievance Decision or Appeal decision is required to be provided under paragraph H. herein, to give the Member a reasonable opportunity to respond prior to that date; and

- b. Before the Plan or the Plan's Designee issues a Grievance Decision or an Appeal Decision based on a new or additional rationale, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Appeal Decision or Grievance Decision is required to be provided under paragraphs H and I. herein, to give the Member, the Member's Representative or Health Care Provider acting on behalf of the Member a reasonable opportunity to respond prior to that date.

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

- 1. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its benefit determination on review of an Adverse Decision in accordance with the following, as appropriate.
  - a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J. herein, of the Grievance Decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the Member's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 24 hours of the orally communicated Grievance Decision.
  - b. Pre-service claims. In the case of a Pre-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J herein, of the Grievance Decision within a reasonable period of time appropriate to the medical circumstances. Oral Notification shall be provided not later than 30 days after the filing date of the Member, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.
  - c. Post-service claims. In the case of a Post-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with item J herein, of the Grievance Decision within a reasonable period of time. Oral Notification shall be provided not later than 45 working days after the filing date of the Member's, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.
- 2. If the Plan or the Plan's Designee does not have sufficient information to complete its Grievance Decision, the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within five (5) working days after the Filing Date of the Grievance by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan or the Plan's Designee. The Plan or the Plan's Designee Notification shall:
  - a. Notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member that it cannot proceed with reviewing the Grievance unless additional information is provided; and
  - b. Assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in gathering the necessary information without further delay.

3. The Plan or the Plan's Designee may extend the 30-day or 45-working day period required for making a Grievance Decision under paragraph H.1.b., c. with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.
4. Calculating time periods. For purposes of Section H. herein, the period of time within which a Grievance Decision shall be made begins at the time a Grievance is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph H.2 herein due to a Member's, the Member's Representative's or Health Care Provider's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member until the date on which the Member, the Member's Representative or Health Care Provider acting on behalf of the Member responds to the request for additional information.
5. In the case of Grievance, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs G.2, G.3, and G.4 herein as is appropriate.

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

1. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its Appeal Decision no later than 60 working days after the filing date of the Member, the Member's Representative's or Health Care Provider's Appeal. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 30 days of the Appeal Decision.
2. The Plan or the Plan's Designee may extend the 60-working day period required for making an Appeal Decision under I.1 with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.
3. Calculating time periods. For purposes of Section I. herein, the 60-working day period within which a benefit determination on review shall be made, subject to any extension granted pursuant to paragraph I.2 above, begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make an Appeal Decision accompanies the filing.

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

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

1. The identity of the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. The specific factual bases for the adverse determination;
3. Reference to the specific criteria and standards, including interpretive guidelines, on which the benefit determination is based;
4. A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Member's Claim For Benefits;
5. A statement describing any voluntary Appeal or Grievance procedures offered by the Plan and the Member's right to obtain the information about such procedures, and a statement of the Member's right to bring an action under Section 502(a) of the Act; and
6.
  - a. If an internal rule, guideline, protocol, 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 Member 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 Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
  - c. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.
7. In the case of a Grievance involving an Adverse Decision, a statement that includes the following information:
  - a. The name, business address and business telephone number of the Medical Director who made the decision;
  - b. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Grievance Decision;
  - c. The Commissioner's address, telephone number, and facsimile number;
  - d. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

- e. The Health Advocacy Unit’s address, telephone number, facsimile number and electronic mailing address;
  - f. The Employee Benefit Security Administration’s telephone number and website address; and
  - g. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.
8. In the case of an Appeal involving a Coverage Decision, a statement that includes the following information:
- a. That the Member, the Member’s Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Appeal Decision; and
  - b. The Commissioner’s address, telephone number, and facsimile number;
  - c. The Employee Benefit Security Administration’s telephone number and website address; and
  - d. A statement that the Health Advocacy Unit is available to assist the Member, the Member’s Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;
  - e. The Health Advocacy Unit’s address, telephone number, facsimile number and electronic mailing address; and
  - f. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.
9. Grievance Decisions and Appeal Decisions are made under the direction of the Chief Medical Officer:

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

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

- 1. Within 4 months after the date of receipt of an Appeal Decision or a Grievance Decision, a Member, the Member’s Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner for review of the Grievance Decision or Appeal Decision.
- 2. A Member, the Member’s Representative or Health Care Provider acting on behalf of the Member may file a Complaint without first exhausting the Plan’s internal Grievance or Appeals process if:
  - a. In the case of an Adverse Decision:
    - i. The Plan or the Plan’s Designee waives the requirement that the internal Grievance process be exhausted before filing a Complaint with the Commissioner;

- ii. The Plan or the Plan's Designee has failed to comply with any of the requirements of the internal Grievance process;
    - iii. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member provides sufficient information and supporting documentation in the Complaint to demonstrate a Compelling Reason.
  - b. In the case of a Coverage Decision, the Complaint involves an Urgent Medical Condition for which care has not been rendered.
- 3. The remaining provisions of this paragraph K. apply to Complaints regarding Adverse Decisions and Grievance Decisions.
  - a. The Commissioner shall notify the Plan or the Plan's Designee of the Complaint within five working days after the date the Complaint is filed with the Commissioner.
  - b. Except for an Emergency Case (Claim Involving Urgent Care), the Plan or the Plan's Designee shall provide to the Commissioner any information requested by the Commissioner no later than seven working days from the date the Plan or the Plan's Designee receives the request for information.
- 4. a. Except as provided in paragraph K.4.b below, the Commissioner shall make a final decision on a Complaint:
  - i. Within 45 days after a Complaint is filed regarding a Pre-Service Claim;
  - ii. Within 45 days after a Complaint is filed regarding a Post-Service Claim; and
  - iii. Within 24 hours after a Complaint is filed regarding a Claim Involving Urgent Care.
  - b. The Commissioner may extend the period within which a final decision is to be made under paragraph K.4.a. for up to an additional 30 working days if:
    - i. the Commissioner has not yet received information requested by the Commissioner; and
    - ii. the information requested is necessary for the Commissioner to render a final decision on the Complaint.
- 5. The Commissioner shall seek advice from an independent review organization or medical expert for Complaints filed with the Commissioner that involve a question of whether a Pre-Service Claim or a Post-Service Claim is Medically Necessary. The Commissioner shall select an independent review organization or medical expert to advise on the Complaint in the manner set forth in Section 15-10A-05 of the Insurance Article.
- 6. The Plan or the Plan's Designee shall have the burden of persuasion that its Adverse Decision or Grievance, as applicable, is correct during the review of a Complaint by the Commissioner or Designee of the Commissioner, and in any hearing held regarding the Complaint.
- 7. As part of the review of a Complaint, the Commissioner or Designee of the Commissioner may consider all of the facts of the case and any other evidence deemed Relevant.
- 8. Except as provided below, in responding to a Complaint, the Plan or the Plan's Designee may not rely on any basis not stated in its Adverse Benefit Determination.

- a. The Commissioner may allow the Plan or the Plan's Designee, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to provide additional information as may be relevant for the Commissioner to make a final decision on the Complaint.
  - b. The Commissioner shall allow the Member, the Member's Representative or Health Care Provider acting on behalf of the Member at least 5 working days to provide the additional information.
  - c. The Commissioner's use of additional information may not delay the Commissioner's decision on the Complaint by more than five working days.
9. The Commissioner may request the Member or a legally authorized designee of the Member to sign a consent form authorizing the release of the Member's medical records to the Commissioner or Designee of the Commissioner that are needed in order for the Commissioner to make a final decision on the Complaint.
10. Subject to paragraphs H, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner if the Member, the Member's Representative or Health Care Provider acting on behalf of the Member does not receive the Plan's Grievance Decision within the following timeframes:
- a. Within 30 days after the filing date of a Grievance regarding a Pre-Service Claim;
  - b. Within 45 working days after the filing date of a Grievance regarding a Post-Service Claim; and
  - c. Within 24 hours after the receipt of a Grievance regarding a Claim Involving Urgent Care.

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

Health Education and Advocacy Unit  
 Consumer Protection Division  
 Office of the Attorney General  
 200 St. Paul Place, 16<sup>th</sup> Floor  
 Baltimore, MD 21202  
 410- 528-1840 or 1-877- 261-8807  
 Fax: 410- 576-6571  
 E-mail: heau@oag.state.md.us

**L. MEMBER COMMENTS AND QUALITY COMPLAINTS**

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

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

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

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

**M. DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEAL PROCESS**

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

**N. MISCELLANEOUS**

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

Members have no Plan 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 affecting them 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 of Maryland, Inc.**



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Chester E. Burrell  
President and Chief Executive Officer

## COMPENSATION AND PREMIUM DISCLOSURE STATEMENT

*Our compensation to providers who offer health care services and behavioral health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.*

*If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your physician, please call our Member Services Department at the number listed on your identification card, or write to:*

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

### A. METHODS OF PAYING PHYSICIANS

This table shows definitions of how insurance carriers may pay physicians (or other providers) for your health care services with a simple example of how each payment mechanism works.	
Terms	The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.
Salary	<p>A physician (or other provider) is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services.</p> <p>Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing pre-natal care to Mrs. Smith, who is a member of the HMO, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have an effect upon Dr. Jones' salary.</p>
Capitation	<p>A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires.</p> <p>Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.</p>

<p>This table shows definitions of how insurance carriers may pay physicians (or other providers) for your health care services with a simple example of how each payment mechanism works.</p>	
<p>Fee-for- Service</p>	<p>A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder.</p> <p>Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.</p>
<p>Discounted Fee-for-Service</p>	<p>Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician (or other provider), who usually gets an increased volume of patients.</p> <p>Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or HMO.</p>
<p>Bonus</p>	<p>A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.</p> <p>An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.</p>
<p>Case Rate</p>	<p>The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care.</p> <p>This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.</p>

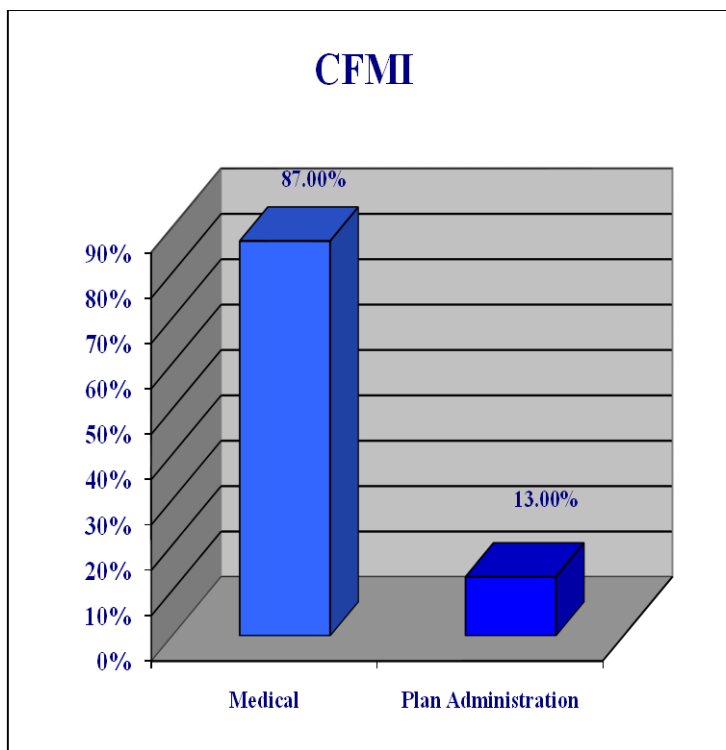
**B. PERCENTAGE OF PROVIDER PAYMENT METHODS**

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

**C. DISTRIBUTION OF PREMIUM DOLLARS**

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

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



## **PATIENT PROTECTION DISCLOSURE NOTICE**

### Primary Care Provider Designation

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

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

### Obstetrics and Gynecological Care

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

## GRANDFATHERED PLAN DISCLOSURE

CareFirst believes the health benefits plan described in this health benefit plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this health benefit plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Group’s human resources department. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

When you have questions about your CareFirst benefits, feel free to call or write CareFirst BlueCross BlueShield.

**Main Office**

National Accounts Dedicated Service

Mail Administrator

P.O. Box 14114

Lexington, KY 40512-4114

