CareFirst
Family of health care plans

CareFirst BlueChoice, Inc.

BlueChoice HMO Open Access HSA (BLUEFUND)

Your Group Contract

840 First Street, NE
Washington, DC 20065

CUT9803-9X (11/16)

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

An independent licensee of the Blue Cross and Blue Shield Association

GROUP CONTRACT

The consideration for this Group Contract is: (1) the Group Contract Application; (2) the payment of premiums when they are due, and (3) the fulfillment of the Group's obligations, set forth herein. CareFirst BlueChoice, Inc. (CareFirst BlueChoice) agrees to provide the benefits described in this Group Contract for a period of 12 months beginning on the Group Effective Date as stated in the Group Contract Application and from year to year after that, unless the Group Contract is amended or terminated in accordance with the terms of this Group Contract.

Group Name: Overseas Building Operations & USAID

Group Number: 1NTS

Effective Date: February 01, 2018

CareFirst BlueChoice, Inc.

These provisions govern the relationship between the Group and CareFirst BlueChoice. As such, they may not be contained in the benefit guides that are provided for the use of Members.

I. Definitions. In addition to the definitions contained in the Evidence of Coverage, the underlined terms, when capitalized in this Group Contract, are defined as follows:

Benefit Materials, as used in this Group Contract, means (i) any enrollment or other coverage information or materials provided by CareFirst BlueChoice to the Group for delivery to Eligible Persons, (ii) the Evidence of Coverage, and (iii) any benefit summaries or other notices or materials relating to the Evidence of Coverage required by federal or state law or regulation to be provided by the Group or CareFirst BlueChoice to Eligible Persons.

Blue Cross and Blue Shield Association, as used in this Group Contract, means the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Eligible Person, as used in this Group Contract, means a person identified in the Evidence of Coverage as eligible to enroll including, but not limited to: (i) employees, (ii) former employees whose eligibility for group coverage has been extended due to COBRA requirements; and, (iii) their eligible dependents.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Group, as used in this Group Contract, means the employer or other organization named on the Group Contract Application and to which CareFirst BlueChoice has issued the Group Contract and Evidence of Coverage

Group Contract Application, as used in this Group Contract, means the Group Contract Application submitted by the Group to CareFirst BlueChoice pursuant to which CareFirst BlueChoice has issued this Group Contract. The Group Contract Application is a part of this Group Contract.

Evidence of Coverage, as used in this Group Contract, means the Evidence of Coverage attached to this Group Contract, including all duly authorized attachments, amendments, and riders.

II. Minimum Enrollment Requirements.
The composition of the Group, the Group's eligibility and enrollment requirements and the structure of the Group's benefit offerings to potential Members which exist on the Effective Date of this Group Contract as stated in this Group Contract or on the Group Contract Application are material to the execution of this Group Contract by CareFirst BlueChoice. Therefore, during the term of this Group contract, no change in the Group's eligibility or participation requirements, or renewal dates shall be permitted unless CareFirst BlueChoice agrees to the change in writing.

III. Group Cooperation - Benefit Materials.

A. The Group shall: (1) deliver to Eligible Persons all Benefit Materials within the timeframes and in the manner specified by law or regulation, or as instructed by CareFirst BlueChoice; and (2) allow CareFirst BlueChoice reasonable access to the Group's employees and other eligible persons for purposes of enrollment. The Group shall promptly provide any information requested by CareFirst BlueChoice to prepare any Benefit Materials.

B. The Group shall maintain a record of its distribution of Benefit Materials to Eligible Persons. The Group shall provide such records to CareFirst BlueChoice within 15 days of request.

C. The Group shall indemnify, defend, and hold harmless CareFirst BlueChoice from all claims, damages, losses and liabilities, including reasonable attorney's fees, arising out of any failure by the Group to provide any Benefit Materials to Eligible Persons within the timeframes specified by law or regulation or as instructed by CareFirst BlueChoice.

IV. Group's Cooperation Obligation Relating to Medicare Secondary Payer and Section 111 Reporting Obligations. This Section applies to CareFirst BlueChoice's reporting obligations under Section 111 of the Medicare, Medicaid and SCHIP Expansion Act of 2007, and related regulations and the coordination of benefits under section 1862(b) of the Social Security Act (collectively 'Section 111").

A. The Group agrees to provide the following information to CareFirst BlueChoice when requested:

1. The Group's federal Employer or Tax Identification Number (TIN).

2. The identification, including federal Employer or Tax Identification Number (TIN), of all parent entities, subsidiary entitles, and any affiliated entities, wherever located, and if the Group filed a consolidated federal tax return with any other entity in the past 12 months, the identification of the entity or entities with whom the consolidated federal tax return was filed.

3. The Group's number of employees (defined as the total number of people employed (both full-time and part-time) by the Group and any parent entities, subsidiary entitles, and any affiliated entities, wherever located.

4. The employment status (i.e. active, retired, COBRA) of all employees and the effective and termination dates of status.

5. The disability status of all employees and dependents, if known, and the effective and/or termination dates of each identified person's disability status.

6. The social security number (SSN) or Health Insurance Claim Number (HICN) for each person covered under the Evidence of Coverage.

B. The Group shall promptly report to CareFirst BlueChoice any change in the number of employees (defined as the total number of people employed (both full-time and part-time) by the Group and any parent entities, subsidiary entitles, and any affiliated entities, wherever located increases from the number reported to CareFirst BlueChoice to (i) more than 20 employees; or (ii) more than 100 employees.

C. For purposes of its reporting and coordination of benefits obligations under Section 111, CareFirst BlueChoice, in its sole discretion, shall determine the number of employees attributable to the Group. This means that CareFirst BlueChoice may treat all employees eligible to enroll under a single health care plan purchased by the Group even though the Group consists of more than one distinct corporate entity. Likewise, CareFirst BlueChoice may combine different corporate entities that have separate health care plans into a single employee group where those different corporate entities are commonly owned or file a consolidated tax return. The Group waives any right to assert any claim against CareFirst BlueChoice based upon any determination made by CareFirst BlueChoice relating to Group's employer size for purposes of Section 111.

D. CareFirst BlueChoice shall, in its sole discretion, coordinate benefits relating to Medicare based upon the employer size information it has received from the Group, and any other information in its possession. The Group waives any right to assert any claim against CareFirst BlueChoice based upon any determination made by CareFirst BlueChoice relating to the coordination of benefits relating to Medicare.

E. Indemnification of CareFirst BlueChoice by the Group. The Group agrees to indemnify, defend, and hold harmless CareFirst BlueChoice and its officers, directors, agents, employees, and affiliates from all demands, claims, damages to persons or property, losses, liabilities, or expenses, including reasonable attorney's fees, arising out of or caused by: (1) any failure or error by the Group in providing the information requested by CareFirst BlueChoice under this section; and (2) any error by CareFirst BlueChoice in coordinating benefits relative to Medicare due to any error or failure by the Group in reporting its employer size to CareFirst BlueChoice.

V. Group Administration.

A. In any case in which the Eligible Person will be responsible for a portion of the monthly premiums upon enrollment, the Group shall make the appropriate payroll deductions, if applicable, for enrolled Members.

B. The Group agrees to furnish CareFirst BlueChoice on a monthly basis, and on CareFirst BlueChoice's approved forms, such information as may reasonably be required by CareFirst BlueChoice for the administration of the coverage provided under this Group Contract.

C. The Group agrees to receive on behalf of all Eligible Persons any notices or other materials furnished by CareFirst BlueChoice and to deliver such notices or materials to these individuals.

VI. Member Effective Dates. Coverage for Eligible Persons enrolled under the Evidence of Coverage becomes effective on the date stated in the Evidence of Coverage.

VII. Payment Provisions.

A. Monthly Premiums. Initial premiums are due on or before the effective date of the Group Contract. Subsequent premiums are due each month on the Premium Due Date. The Premium Due Date is the first day of the month for the period for which the premium applies.

B. Grace Period. Except for the initial premium(s), there is a grace period following the Premium Due Date within which overdue premiums can be paid without loss of coverage.

1. A grace period of 31 days following the Premium Due Date will be granted for payment of each monthly premium due subsequent to payment of the first premium. No grace period shall apply if CareFirst BlueChoice does not intend to renew the Group Contract beyond the period for which premiums have been accepted and notice of the intention not to renew is delivered to the Group at least 45 days before the premium is due. During the grace period the Group Contract shall continue in force.

2. Unless CareFirst BlueChoice receives a notice of the Group's intention to terminate the Group Contract before the end of the grace period, CareFirst BlueChoice will collect the premium for the 31-day grace period.

3. If CareFirst BlueChoice receives a notice of the intention to terminate the Group Contract during the grace period, CareFirst BlueChoice will collect the premium for the period beginning on the first day of the grace period until the date on which notice is received, or the date of termination stated in the notice, whichever is later.

4. If the premium for the 31-day grace period is paid after the grace period ends, CareFirst BlueChoice may charge interest for the premium, but interest may not

begin to accrue during the 31-day grace period, and the interest rate charged will not exceed an effective rate of 6 percent per year.

5. Non-Payment of Premiums. If premiums are not received by the Premium Due Date and CareFirst BlueChoice does not receive a notice of the Group's intention to terminate the Group Contract, CareFirst BlueChoice will notify the Group in writing of the overdue premiums. If CareFirst BlueChoice receives payment of all amounts listed on the notice prior to the end of the grace period, coverage will continue without interruption. If CareFirst BlueChoice does not receive full payment prior to the end of the grace period, CareFirst BlueChoice will, upon notice to the Group, terminate the Group Contract, effective as of 11:59 p.m. Eastern Time on the last day of the grace period. Members will be liable for the cost of any benefit provided or paid by CareFirst BlueChoice for services received after the effective date of termination subject to the extension of benefits provision. The Group will be liable for all premiums or other outstanding charges incurred up to and including the date of termination.

C. Payment of all premiums is a condition precedent to the performance of CareFirst BlueChoice's duties and obligations hereunder. The Group will remit a premium for each Member under the terms of this Group Contract.

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

1. New enrollment will result in additional premium charges due; and

2. Terminations will result in a credit toward the premium charges due.

E. Retroactive Termination of Members. When the Group fails to provide prospective notice of a Member's termination, CareFirst BlueChoice will only retroactively terminate a Member's coverage to 11:59 p.m., Eastern Time, on the last day of the month prior to the month in which the notice of termination is received by CareFirst BlueChoice or; if claims have been received and processed, the day after such processing.

For example, if CareFirst BlueChoice receives retrospective notice of termination on December 16, CareFirst BlueChoice will only retroactively terminate a Member's coverage to November 30. However, if claims have been received and processed after such date, then CareFirst BlueChoice will terminate coverage the day after such processing. For example, if claims are received and processed December 5, termination will be December 6.

The Group agrees to indemnify and hold harmless CareFirst BlueChoice, 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 creditable 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.

F. Premium Increases. CareFirst BlueChoice reserves the right to increase a premium during the contract period. The Group will be notified of a premium increase by mail or, if consent has been given, by e-mail to the Group's last known e-mail address 45 days prior to the effective date of the new premium. If, however, the proposed premium rate

increase exceeds 35% of the annual premium charged, CareFirst will give the Group prior written notice of no less than 60 days.

VIII. Misstatement of Age. If the benefits or premium set out in this Group Contract vary based on the Member's age, and if the age of a Member is misstated by the Subscriber or Group, an equitable adjustment of the benefits or premium will be made by CareFirst BlueChoice. Any benefit determinations or premium charges made based on the Member's misstated age will be adjusted by CareFirst BlueChoice as soon as reasonably possible by recalculating the benefit or premium using the correct age, and written notification will be sent to the Member.

IX. Premium Rebates. This Section applies if CareFirst BlueChoice is required under federal or state law to rebate any portion of a premium paid under the Group Contract by the Group or its Subscribers (a "Rebate").

A. Cooperation in Distribution of Rebates. The Group agrees to assist CareFirst BlueChoice with the distribution of any Rebate. The Group will timely provide all information requested by CareFirst BlueChoice, in the format requested by CareFirst BlueChoice, related to the distribution of any Rebate. This information shall include, but is not limited to whether the Group is governed by the ERISA, and Subscriber address information.

B. Determination of Rebate Amount. CareFirst BlueChoice is solely responsible for determining, under applicable law, whether any Rebate is due to the Group or any Subscriber and the amount of any Rebate.

C. Distribution of Rebates. CareFirst BlueChoice may pay any Rebate to the Group and/or to Subscribers. CareFirst BlueChoice will, in its sole discretion and under applicable law, determine how Rebates will be distributed to the Group and Subscribers. The Group agrees to be bound by CareFirst BlueChoice's determinations regarding the distribution of any Rebate.

D. Assurances by Group. If CareFirst BlueChoice distributes a Rebate to the Group, the Group will retain, use or distribute all portions of the Rebate in compliance with governing law. The Group represents and provides assurances that (i) it has made a determination regarding whether it is a group health plan that is governed by ERISA; (ii) if the Group determines that it is governed by ERISA, the Group will distribute any Rebate in accordance with its obligations under ERISA; and (iii) if the Group has determined that it is not governed by ERISA, the Group will dispose of any Rebate in accordance with its obligations under 45 C.F.R. § 158.242, as amended or restated from time to time. The Group agrees to provide CareFirst BlueChoice, upon request, with any further written assurance regarding these matters at the time any Rebate is distributed by CareFirst BlueChoice to the Group.

E. Tax Procedure. The parties agree that CareFirst BlueChoice is not the statutory employer of any Subscriber. To the extent that any portion of a Rebate paid to a Subscriber by CareFirst BlueChoice or the Group is taxable as wages, the Group shall be treated as the sole employer who paid those wages and for whom work was performed. The Group agrees that it will: (1) determine the taxable portion of any Rebate; and (2) provide, where required by law, appropriate tax withholding and reporting relating to any Rebate paid to the Group or Subscribers (including, but not limited to, the preparation and submission of any Forms W-2, 1099, or similar federal and state tax forms used to report the receipt of wages or income).

F. Indemnification of CareFirst BlueChoice by the Group. The Group agrees to indemnify, defend, and hold harmless CareFirst BlueChoice and its officers, directors, agents, employees, and affiliates from all demands, claims, damages to persons or property, losses, liabilities, or expenses, including reasonable attorney's fees, arising out of or caused by: (1) any failure by the Group to use, allocate, distribute, or otherwise dispose

of a Rebate (including, but not limited to, the Group's performance any tax reporting obligation stated in subsection E, above, of this Section) in the manner required by law; or (2) a breach of any assurance or representation given by the Group to CareFirst BlueChoice made in subsection D, above, of this section or otherwise provided to CareFirst BlueChoice relating to any Rebate.

X. Amendment Procedure. Amendments must be consistent with state law. CareFirst BlueChoice may amend the Group Contract with respect to any matter, including premium rates, by mailing or, if consent has been given, by e-mailing to the Group's last known e-mail address a notice, including any amendment(s), where applicable, to the Group at its address of record with CareFirst BlueChoice at least 45 days before the amendment(s) are to take effect.

A. All such amendments are deemed accepted by the Group unless the Group gives CareFirst BlueChoice written notice of nonacceptance within 15 days following the notice date, in which event the Group may cancel the Group Contract effective as of the renewal date, upon written notice to CareFirst BlueChoice. If state or federal law mandates an amendment, it will be automatically deemed accepted by the Group.

B. Regardless of when the amendment is received, the Evidence of Coverage and this Group Contract are considered to be automatically amended of the date specified in the contract amendment or the notice (if not stated in the contract amendment), unless otherwise mandated, to conform with any applicable changes to state or federal law.

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

XI. Contract Renewal. CareFirst BlueChoice will renew this Group Contract no later than 45 days prior to the Contract Renewal Date, except as outlined in the Termination of Group Contract provision below.

XII. Termination of Group Contract. The Group Contract may be terminated as follows:

A. At any time, the Group may terminate the Group Contract. Such termination shall be effective at midnight on the termination date specified by the Group. The Group will be responsible for providing a notice to each Member.

B. This Group Contract will terminate at 12:01 a.m. Eastern Time, on the date that there is no longer any Member who lives, resides, or works in the Service Area. CareFirst BlueChoice will send written notice of termination to the Group and all Members as soon as practicable after notice of such cessation or relocation.

C. CareFirst BlueChoice may terminate the Group Contract for one of the following reasons:

1. Failure of the Group to pay premiums or any other payment due under the terms of the Group Contract.

2. The Group has performed an act or a practice that constitutes fraud, in which case, termination will be immediate.

3. The Group has failed to comply with a material plan provision in the Group Contract relating to the employer contributions or group participation rules, in which case, termination will be immediate.

4. The Group has made an intentional misrepresentation of material fact under the terms of the coverage, in which case, termination will be immediate.

5. CareFirst BlueChoice elects not to renew all of a particular type of coverage or policy form in the state. In this case CareFirst BlueChoice will provide notice of the nonrenewal at least 90 days before the date of the nonrenewal to each affected Subscriber and Group, offer to each affected Group the option to purchase any other health insurance coverage currently being offered by CareFirst BlueChoice, and act uniformly without regard to the claims experience of any affected Group, or any Health Status-Related Factor of any affected individual.

   Health Status-Related Factor means a factor related to health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability including conditions arising out of acts of domestic violence, or disability.

6. CareFirst BlueChoice elects not to renew all group health insurance coverage in the state. In this case, CareFirst BlueChoice will provide notice of the nonrenewal at least 180 days before the date of the nonrenewal to the affected individuals and Group, give notice to the Commissioner of Insurance at least 30 working days before the notice referred to above, not sell new business for groups in the state for a 5-year period beginning with the date of such notice to the Commissioner, and act uniformly without regard to the claims experience of any affected Group, or any Health Status-Related factor of any affected individual.

D. The Group will be liable for all premiums and other outstanding charges up to and including the date of termination. The Group and/or Members will be liable for the cost of any services provided or paid by CareFirst BlueChoice for services received on or after the date of termination.

XIII. Insolvency. In the event of insolvency, CareFirst BlueChoice's rights under the Group Contract (including, but not limited to, all rights to premiums to the extent permitted by applicable bankruptcy law) shall become vested in any person or entity that guarantees payment and actually pays for the services and benefits that CareFirst BlueChoice is obligated to make available under the Group Contract.

XIV. Contestability of Coverage. This Group Contract may not be contested, except for nonpayment of premiums, after it has been in force for 2 years from its date of issue. Any rescission of coverage of the Group or of any Member shall only be based upon an act, practice or omission that constitutes fraud or is due to an intentional misrepresentation of material fact. Absent fraud, each statement made by an applicant, Group, or Member is considered to be a representation and not a warranty. A statement made to effectuate coverage may not be used to avoid the coverage or reduce benefits under this Group Contract unless the statement is contained in a written instrument signed by the Group or Member, and a copy of the statement is given to the Group or Member. CareFirst will provide 30-days advance written notice of any rescission of coverage and refund any paid premiums to the Group. The Group is responsible for repayment of any claim payment made by CareFirst BlueChoice on behalf of any Member whose coverage has been rescinded. CareFirst BlueChoice reserves the right to set off against any premium refund the amount of any claim payment made by CareFirst BlueChoice on behalf of any Member whose coverage has been rescinded. This provision does not preclude the assertion at any time of defenses to any claim based upon the person's ineligibility for coverage under this Group Contract or upon other provisions in this Group Contract.

XV. Blue Cross and Blue Shield Association Plan Disclosure. The Group, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Contract constitutes a contract solely between the Group and CareFirst BlueChoice; that CareFirst BlueChoice is an

independent corporation operating under a license from the Blue Cross and Blue Shield Association permitting CareFirst BlueChoice to use the Blue Cross and Blue Shield Service Marks in the District of Columbia, Maryland, and portions of Virginia; and that CareFirst BlueChoice is not contracting as the agent of the Blue Cross and Blue Shield Association. The Group, on behalf of itself and its Members, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than CareFirst BlueChoice; and no person, entity, or organization other than CareFirst BlueChoice shall be held accountable or liable to the Group for any of CareFirst BlueChoice's obligations to the Group created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of CareFirst BlueChoice other than those obligations created under other provisions of this Contract.

XVI. Regulatory Compliance. CareFirst BlueChoice has not provided any document intended to constitute a Plan Document or a Summary Plan Description for purposes of ERISA. The Group is the party responsible for the preparation of the Plan Document and the preparation and distribution of the Summary Plan Description.

For purposes of ERISA and/or COBRA (or comparable provisions of other state or federal law), the Group is the "plan sponsor" and the "administrator" of the group health benefits plan, the benefits of which are set out in this Group Contract. It is the Group's responsibility to comply with all applicable law and regulation, including, but not limited to, all disclosure and reporting requirements under both ERISA and COBRA (or comparable provisions of other state or federal law). In particular, upon enrollment and upon the occurrence of a "qualifying event" (as that term is defined under COBRA), it is the Group's responsibility to notify Members of their rights under COBRA and to determine whether, and to what extent, they are eligible to elect and/or continue coverage under COBRA. Further, it is the Group's responsibility to determine whether an order received by the Group with respect to employees of the Group and their children is a "qualified medical child support order" (as that term is defined under ERISA and/or applicable state law) and whether such children are eligible for coverage under this Group Contract. The parties expressly understand and agree that this Group Contract, including the portions that are to be distributed to the Members, do not necessarily satisfy all requirements for a "written plan document" or a "summary plan description" (as those terms are defined under ERISA).

XVII. Xerox HR Solutions, LLC, (XHR) Notice. XHR, directly through its affiliates, subcontractors, alliance relationships and/or other agents, will be made available to Members in the high deductible group health plan as custodian of the assets in HSAs (as defined in Section 223 of the Internal Revenue Code) and to provide certain debit card and other banking services. XHR shall be held harmless from and against any and all liability to all actions, causes of action and losses, related to claims arising out of CareFirst BlueChoice's act or omissions with respect to this Group Contract. This limitation of liability does not extend to claims that arise due to XHR's gross negligence or willful misconduct or XHR's failure to comply with applicable law.

XVIII. Record of Medical Claims Experience. Upon request, CareFirst BlueChoice will provide to a Group that averaged at least 100 individuals on business days in the preceding 12-month period, a complete record of the Group's medical claims experience or medical costs incurred under the Contract.

A. The Group must request this record at least thirty (30) days prior to the next change in the Group's premiums or the date that the Contract is amended.

B. The record will include all medical claims or medical costs incurred for the lesser of (1) the period of time that has elapsed since the effective date of this Contract, or (2) the period of time that has elapsed since the Contract was last renewed, reissued or extended, if already issued.

C. Upon the Group's timely request, CareFirst BlueChoice will provide in addition to the above record:

1. A summary of medical claims charges or medical costs incurred and the amount paid with respect to those claims for the most recently available 24-month period;

2. A listing of the number of subscribers for whom combined medical claims payments or medical costs exceed $100,000 for the most recently available 12-month period and for the preceding 12 months if not previously provided, with information as to whether these subscribers from the most recently available 12-month period remain enrolled under the Plan, and provided that the Group and CareFirst may agree to provide the listing for amounts less than $100,000; and

3. Total enrollment in each membership type as of the end of the most recently available 12-month period.

The Group must request this record in writing at least 45 days prior to the next change in the Group's premiums or the date that the Contract is amended and CareFirst shall provide the record within 20 business days.

XIX. Notices.

A. Notices to Members required under this Group Contract shall be in writing directed either to the Subscriber's last known address or, if consent has been given, by e-mail to the Subscriber's last known e-mail address. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst BlueChoice of an address or e-mail address change. The notice will be effective on the date mailed or sent by e-mail, whether or not the Member in fact receives the notice or there is a delay in receiving the notice.

B. Notices to the Group will be sent either by first class mail to the address set forth in the Group Contract Application or, if consent has been given, by e-mail to the Group's e-mail address. Notice will be effective on the date of receipt by the Group, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service.

1. The Group may change the address or, in the manner specified in the Group's consent to receive electronic notices, the Group's e-mail address at which notice is to be given by giving written notice thereof to CareFirst BlueChoice.

2. If the Group is a brokered account, notices to the Group required or arising under the Group Contract will be effectively given by CareFirst BlueChoice by sending such notice directly to the Group as set forth above or, alternatively, by providing notice in the manner described above to the Group's current broker of record as recognized and listed in CareFirst BlueChoice's records. The Group will promptly notify CareFirst BlueChoice of any change in the designated broker under the Group Contract.

C. Except with regard to the Group's consent to receive electronic notices, when notice is sent to CareFirst BlueChoice, it must be sent by first class mail to:

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

Notice will be effective on the date of receipt by CareFirst BlueChoice, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as

certified by the Postal Service. CareFirst BlueChoice may change the address at which notice is to be given by giving written notice to the Group.

D. CareFirst BlueChoice will notify the Group in writing of any changes that may result in a reduction of benefits no less than 90 days before the date on which the change will become effective.

XX. Electronic Notices. If the Group has agreed to receive electronic notices:

A. CareFirst BlueChoice may send the following notices and documents may be provided electronically to the Group:

1. Communications required by this Group Contract, the Evidence of Coverage by federal or state law.

2. Communications relating to the products or services the Group receives from CareFirst BlueChoice, including but not limited to enrollment, wellness program information and notices (including disease management and wellness preventive information), and similar notices.

3. Information on new or additional products, services, or programs offered by CareFirst BlueChoice.

B. The Group may revoke its consent to receive the electronic notices at any time.

C. The Group can change its consent elections or its email address online, at any time.

D. The Group may obtain a paper copy of any electronically furnished notice or document free of charge.

E. In order to access information provided electronically, the Group must have the following:

1. A computer with Internet access

2. An email account that allows the Group to send and receive emails

3. Internet Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

XXI. Entire Contract. The entire contract between the Group and CareFirst BlueChoice consists of this Group Contract, the Group Contract Application, the rate sheet executed or accepted by the Group, the Evidence of Coverage and all duly authorized attachments referred to therein, and any duly authorized riders, endorsements, and amendments attached to this Group Contract or to the Evidence of Coverage. No amendment or modification of any term or provision is valid until approved by an executive officer of CareFirst BlueChoice and unless the approval is endorsed on the policy and attached to the Evidence of Coverage or Group Contract. No other person has authority to change this Evidence of Coverage or Group Contract or waive any of its provisions.

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

XXII. Group Statement. The Group agrees that in the making of this Group Contract, it is acting for and on behalf of itself and as the agent representative of its Eligible Persons; and it is agreed and understood that the Group is not the agent or representative of CareFirst BlueChoice for any purpose of this Group Contract.

XXIII. Assignment. The Group Contract is not assignable by the Group without the written consent of CareFirst BlueChoice.

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

An independent licensee of the Blue Cross and Blue Shield Association

2015 GROUP CONTRACT AMENDMENT

This amendment is effective _____. If no date is shown, this amendment is effective on the effective date or renewal date of the Group Contract to which this amendment is attached.

The Group Contract is amended as follows:

Section VII.B of the Group Contract is deleted and replaced with the following:

B. Grace Period. Except for the initial premium(s), there is a grace period beginning on the Premium Due Date within which overdue premiums can be paid without loss of coverage.

1. A grace period of 31 days beginning on the Premium Due Date will be granted for payment of each monthly premium due subsequent to payment of the first premium. No grace period shall apply if CareFirst BlueChoice does not intend to renew the Group Contract beyond the period for which premiums have been accepted and notice of the intention not to renew is delivered to the Group at least 45 days before the premium is due. During the grace period the Group Contract shall continue in force.

2. Unless CareFirst BlueChoice receives a notice of the Group's intention to terminate the Group Contract before the end of the grace period, CareFirst BlueChoice will collect the premium for the 31-day grace period.

3. If CareFirst BlueChoice receives a notice of the intention to terminate the Group Contract during the grace period, CareFirst BlueChoice will collect the premium for the period beginning on the first day of the grace period until the date on which notice is received, or the date of termination stated in the notice, whichever is later.

4. If the premium for the 31-day grace period is paid after the grace period ends, CareFirst BlueChoice may charge interest for the premium, but interest may not begin to accrue during the 31-day grace period, and the interest rate charged will not exceed an effective rate of 6 percent per year.

5. Non-Payment of Premiums. If premiums are not received by the Premium Due Date and CareFirst BlueChoice does not receive a notice of the Group's intention to terminate the Group Contract, CareFirst BlueChoice will notify the Group in writing of the overdue premiums. If CareFirst BlueChoice receives payment of all amounts listed on the notice prior to the end of the grace period, coverage will continue without interruption. If CareFirst BlueChoice does not receive full payment prior to the end of the grace period, CareFirst BlueChoice will, upon notice to the Group, terminate the Group Contract, effective as of 11:59 p.m. Eastern Time on the last day of the grace period. Members will be liable for the cost of any benefit provided or paid by CareFirst BlueChoice for services received after the effective date of termination subject to the extension of benefits provision. The Group will be liable for all premiums or other outstanding charges incurred up to and including the date of termination.

Section X., Amendment Procedure, of the Group Contract is deleted and replaced with the following:

X. Uniform Modification and Amendment Procedure

A. Uniform Modification
CareFirst BlueChoice reserves the right to modify the Evidence of Coverage and Group Contract at renewal.

B. Amendment Procedure
Amendments must be consistent with state law. CareFirst BlueChoice may amend the Evidence of Coverage and Group Contract with respect to any matter, including premium rates, by mailing or, if consent has been given, by e-mailing to the Group's last known e-mail address a notice, including any amendment(s), where applicable, to the Group at its address of record with CareFirst BlueChoice at least 45 days before the Contract Renewal Date.

1. All such amendments are deemed accepted by the Group unless the Group gives CareFirst BlueChoice written notice of non-acceptance within 15 days following the notice date, in which event the Group may cancel the Group Contract effective as of the renewal date, upon written notice to CareFirst BlueChoice. If state or federal law mandates an amendment, it will be automatically deemed accepted by the Group.

2. Regardless of when the amendment is received, the Evidence of Coverage and the Group Contract are considered to be automatically amended as of the date specified in the contract amendment or the notice (if not stated in the contract amendment), unless otherwise mandated, to conform with any applicable changes to state or federal law.

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

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

CareFirst BlueChoice, Inc.

Chester E. Burrell
President and Chief Executive Officer

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

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

IMPORTANT INFORMATION REGARDING THE MEMBER'S INSURANCE

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 BlueChoice and the Group. The Group's payment and CareFirst BlueChoice's issuance make the Group Contract's terms and provisions binding on CareFirst BlueChoice and the Group.

The Group reserves the rights to change, modify, or terminate the plan, in whole or in part.

Members have no benefits after a plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of the plan termination and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state, or local law.

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

CareFirst BlueChoice recommends that the Member familiarizes himself or herself with the CareFirst BlueChoice complaint and appeal procedure, and make use of it before taking any other action.

If the Member has been unable to contact or obtain satisfaction from CareFirst BlueChoice or the agent, the Member may contact the Virginia State Corporation Commission's Bureau of Insurance at the address and phone number provided in the Benefit Determinations and Appeals document (Attachment A). Written correspondence is preferable so that a record of the inquiry is maintained. When contacting the agent, company or the Bureau of Insurance, have the policy number available.

Group Name: Overseas Building Operations & USAID

Group Number: 1NTS

Effective Date: February 01, 2018

CareFirst BlueChoice, Inc.

Chester E. Burrell
President and Chief Executive Officer

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SECTION 1
DEFINITIONS

The underlined terms when capitalized are defined as follows:

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

Adult means an individual 18 years old and older.

Allowed Benefit

For a Contracting Physician or Contracting Provider, the Allowed Benefit for a Covered Service is the lesser of:

a. the actual charge; or
b. the amount CareFirst BlueChoice allows for the service in effect on the date that the service is rendered.

The benefit payment is made directly to the Contracting Physician or the Contracting Provider and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance as stated in the Schedule of Benefits. The Member is responsible for any applicable Deductible, Copayment or Coinsurance stated in the Schedule of Benefits, and the Contracting Physician or Contracting Provider may bill the Member directly for such amounts.

For a Non-Contracting Physician or a Non-Contracting Provider, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit for a Contracting Physician or Contracting Provider. Benefits are payable to the Member or to the provider, at the discretion of CareFirst BlueChoice. It is the Member's responsibility to apply any CareFirst BlueChoice payments to the claim from the Non-Contracting Physician or Non-Contracting Provider.

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 administrative 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 a Contract year basis.

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

Contract Renewal Date means the date specified in the Eligibility Schedule, on which this Evidence of Coverage renews and each annual anniversary of such date.

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

Contracting Provider means any physician, health care professional or health care facility that has entered into a contract with CareFirst BlueChoice to provide Covered Services to Members and has been designated by CareFirst BlueChoice as a Contracting Provider.

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

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

Copayment (Copay) means the dollar amount that a member must pay for certain Covered Services.

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 BlueChoice.

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

Deductible means the dollar amount of Covered Services, based on the Allowed Benefit, which must be incurred before CareFirst BlueChoice 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 himself or herself.

Dependent means a Member who is covered under this 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:

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

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

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

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

Emergency Services also include a health condition that would be terminal without the requested treatment, as determined by the person's treating health care provider.

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

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

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:

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

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

C. The Technology must improve the net health outcome;

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

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

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

A drug is not considered Experimental or Investigational as long as: it is used to treat a covered indication; it has been approved by the FDA for at least one indication; and, it is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer review medical literature.

FDA means the federal Food and Drug Administration.

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

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

Hospital means any facility in which the primary function is the provision of diagnosis, treatment, and medical and nursing services, surgical or non-surgical and that is:

A. Licensed by the appropriate State authorities; or

B. Accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

C. Approved by Medicare.

The facility cannot be, other than incidentally: a convalescent home, convalescent rest or nursing facilities; facilities primarily affording custodial, educational or rehabilitative care; or facilities for the aged, drug addicts or alcoholics.

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

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

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

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

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

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

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

3. not primarily for the convenience of a patient or health care provider; and

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

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

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

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

Non-Contracting Provider means any physician, health care professional or health care facility that is not contracted with CareFirst BlueChoice to provide Covered Services to Members.

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 limits the maximum amounts that the Member will have to pay for his/her share of benefits in any Benefit Period. Once the Member meets the Out-of-Pocket Maximum, the Member will no longer be required to pay Copayments or his/her share of the Coinsurance for the remainder of that Benefit Period.

Primary Care Physician ("PCP") means a Contracting Physician or Contracting Provider selected by a Member to provide and manage the Member's health care.

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 that complies with Section 609(A) of the Employee Retirement Income Security Act of 1974, as amended.

Service Area means the geographic area within which CareFirst BlueChoice's services are available, with the exception of emergency and urgent care services. CareFirst BlueChoice may amend the defined Service Area at any time by notifying the Group in writing.

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

Spouse means 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.

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

Type of Coverage means either Individual, which covers the Subscriber only, or Family, under which a Subscriber may also enroll his or her Dependents. In addition, some Group Contracts include additional categories of coverage, such as Individual and Adult, Individual and Child, or Individual and Children. The Type of Coverage available is described in the Evidence of Coverage.

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

SECTION 2
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 the CareFirst BlueChoice approves them in advance, in writing. To be covered under this 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 this Evidence of Coverage;

B. The individual must elect coverage during certain periods defined in this Evidence of Coverage;

C. The Group must notify CareFirst BlueChoice 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.

Note: No individual is eligible as both a Subscriber and Dependent. If both a husband and wife are eligible as Subscribers, they may not both have Individual and Adult Coverage or Family Coverage.

2.2 Eligibility of Subscriber. To enroll as a Subscriber, the individual must reside or work in the Service Area. In addition, the individual must meet CareFirst BlueChoice's standard eligibility requirements and any additional 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, 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). A Subscriber cannot cover a former Spouse once divorced or if the marriage had been annulled.

2.4 Eligibility of Dependent Children. If the Group has elected to include coverage for Dependent children of the Subscriber or a Subscriber's covered Spouse under this Evidence of Coverage, then a Subscriber may enroll a Dependent child. To be eligible as a Dependent child, the child must:

A. Meet the requirements described in Section 2.5 below;

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 twelve (12) months duration, and who resides with, and is the Dependent of, the Subscriber or Spouse;

3. A grandchild who is in the court-ordered custody, and who resides with, and is the Dependent of, the Subscriber or Spouse; or

4. A stepchild who permanently resides in the Subscriber's household and who is dependent upon the Subscriber or the Subscriber's Spouse for more than half of his or her support.

D. Be subject to a Medical Child Support Order ("MCSO") or Qualified Medical Support Order ("QMSO") as stated herein:

Upon receipt of a MCSO or QMSO, when coverage of the Subscriber's family members is available under this Evidence of Coverage, then CareFirst BlueChoice will accept enrollment submitted by the Subscriber regardless of enrollment period restrictions. If the Subscriber does not attempt to enroll the child, then CareFirst BlueChoice will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any State or the District of Columbia. If the Subscriber has not completed any applicable waiting periods 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 BlueChoice receives the MCSO/QMSO, CareFirst BlueChoice 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**.**

1. Enrollment for a child subject to a MCSO/QMSO will not be denied because the child:

   a. was born out of wedlock.

   b. is not claimed as a dependent on the Subscriber's federal tax return.

   c. does not reside with the Subscriber.

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

   e. does not reside in the Service Area.

2. When a child subject to a MCSO or QMSO does not reside with the Subscriber, CareFirst BlueChoice will:

   a. send the non-insuring, custodial parent ID cards, claim forms, the applicable Evidence of Coverage or Member contract and any information necessary to obtain benefits;

   b. allow the non-insuring, custodial parent or a provider of a Covered Service to submit a claim without the prior approval of the Subscriber;

   c. provide benefits directly to:

      i) the non-insuring, custodial parent;

      ii) the provider of the Covered Services; or,

      iii) the appropriate child support enforcement agency of any State or the District of Columbia.

E. 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 Covered Dependent Children.

A. All covered Dependent children are eligible for coverage up to the Limiting Age for Dependent children, 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 whose attendance at a public or private high school, college, university, graduate school, trade school or other school at which the Dependent child is enrolled meets the institution's requirements for full-time status.

2. The Member must provide CareFirst BlueChoice 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 BlueChoice has the right to verify eligibility status.

3. CareFirst BlueChoice will provide coverage for an eligible Dependent child who is enrolled as a full-time student and is unable, due to a medical condition, to continue as a full-time student. Coverage will continue for a period of 12 months from the date the Dependent child ceases to be a full-time student or until the Dependent child attains the Limiting Age for Student Dependents as stated in the Eligibility Schedule, whichever occurs first. CareFirst BlueChoice may request certification from the Dependent child's treating provider that the child's absence is and/or was Medically Necessary. A child's status as a full-time student shall be determined in accordance with the criteria specified by the institution in which the child is enrolled.

C. A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if:

1. The Dependent child is incapable of supporting himself or herself because of mental or physical incapacity;

2. The incapacity occurred before the covered Dependent child reached the Limiting Age or, if the child was covered beyond the Limiting Age as a Student Dependent, the incapacity occurred before the covered Dependent child reached the Student Dependent Limiting Age specified in the Eligibility Schedule;

3. The Dependent child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse for support and maintenance; and

4. The Subscriber provides CareFirst BlueChoice with proof of the Dependent child's medical or mental incapacity within 31 days after the Dependent child's coverage would otherwise terminate. CareFirst BlueChoice has the right to verify whether the child is and continues to qualify as an incapacitated Dependent child.

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 the Special Enrollment Periods Section.

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 BlueChoice and all other alternate health care plans available through the Group, without individual underwriting or imposition of waiting periods, exclusions or limitations for pre-existing conditions.

2. In addition, Subscribers already enrolled in CareFirst BlueChoice 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 within thirty (30) days after the new subscriber eligibility date 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. 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.

1. Special enrollment for certain individuals who lose coverage:

a) CareFirst BlueChoice 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.

b) 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 1.c) i), ii), or iii) of this section, and if applicable, paragraph 1.c) 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 packaged 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 1.c) i), ii), or iii) of this section, and if applicable, paragraph 1.c) iv) of this section.

B) However, CareFirst BlueChoice is not required to enroll any other Dependent unless the Dependent satisfies the criteria of this paragraph 1.b) ii), or the employee satisfies the criteria of paragraph 1.b) i) of this section.

c) 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 1.c) 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 include 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 1.c) 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 BlueChoice 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 BlueChoice requires such a statement, and an employee does not provide it, the Group and CareFirst BlueChoice are not required to provide special enrollment to the employee or any Dependent of the employee under this paragraph. The Group and CareFirst BlueChoice 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 BlueChoice cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst BlueChoice cannot require that the statement be notarized.)

d) Enrollment will be effective as stated in the Eligibility Schedule.

2. Special enrollment with respect to certain Dependent beneficiaries:

a) Provided the Group provides coverage for Dependents, CareFirst BlueChoice will permit the individuals described in paragraph 2.b) 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.

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

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

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

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

B) The individual is a Spouse of a participant and a child becomes a Dependent of the participant through birth, Adoption, or placement for Adoption.

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

A) The employee and the Spouse become married; or

B) The employee and Spouse are married and a child becomes a Dependent of the employee through birth, Adoption, or placement for Adoption.

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

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

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

c) Enrollment will be effective as stated in the Eligibility Schedule.

3. If a Subscriber enrolls within 31 days of any event described in Section 2.6.C, above, the Subscriber and his or her Dependents will be treated as timely enrolled.

D. Newly Eligible Dependent Children. If the Group has elected to include coverage for the Subscriber's Dependent children under this Evidence of Coverage, then a Subscriber may add a Dependent child to this Evidence of Coverage outside the Open Enrollment period as described below. Other than the categories of Dependent children listed below,

eligible Dependent children can only be added to this Evidence of Coverage during the Group's Open Enrollment period or special enrollment period, except as stated in 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 or stepchild shall be payable from the moment of birth and shall continue for 31 days after the date of birth.

2. for an eligible stepchild (non-newborn) shall be payable from the date the stepchild became a Dependent of the Subscriber or the Dependent Spouse and shall continue for 31 days after that date.

3. for an eligible grandchild shall be payable from the date of court-ordered custody and shall continue for 31 days after that date.

4. for a newly adopted child shall be payable from the date of the Adoption of the child and shall continue for 31 days after the date of Adoption of the child.

5. for a minor for whom guardianship of at least twelve (12) months duration 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 Dependent 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 Dependent child is not received within the 31-day period and the additional premium is not paid.

When the addition of a Dependent child does not change the Subscriber's Type of Coverage, coverage will continue beyond the 31-day period, however, the Subscriber is requested to provide CareFirst BlueChoice with written notice enrolling the eligible Dependent child.

Coverage for the Dependent children listed above shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

2.7 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.

2.8 Clerical or Administrative Error. Clerical or administrative errors by the Group or CareFirst BlueChoice 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.

2.9 Cooperation and Submission of Information. CareFirst BlueChoice may require verification from the Group and/or Subscriber pertaining to the eligibility of any Subscriber or Dependent enrolled hereunder. The Group and/or Subscriber agree to cooperate with and assist CareFirst BlueChoice, including providing CareFirst BlueChoice with reasonable access to Group records upon request.

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

SECTION 3
TERMINATION OF COVERAGE

3.1 Disenrollment of Individual Members. Coverage of individual Members will terminate on the date stated in the Eligibility Schedule.

A. CareFirst BlueChoice can terminate a Member's coverage with immediate notice of termination in the following situations:

1. The Member no longer meets the conditions of eligibility.

2. The Member no longer works or resides in CareFirst BlueChoice's Service Area.

B. CareFirst BlueChoice can terminate a Member's coverage with 31 days prior written notice for the following reasons:

1. Nonpayment of charges when due, including premium contributions that may be required by the Group, Copayment, Coinsurance and applicable Deductible, if any.

2. Violation of reasonable published policies of CareFirst BlueChoice, or an inability of the medical staff and the Member to establish a reasonable physician-patient relationship.

3. Fraudulent use of CareFirst BlueChoice identification 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.

4. Fraud or material misrepresentation in enrollment or in the use of services or facilities.

C. 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.

D. 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.

E. 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.

F. 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 BlueChoice to remove an eligible Dependent from coverage.

G. 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.

H. The Subscriber is responsible for notifying CareFirst BlueChoice (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 BlueChoice of these types of changes and it is later determined that a Dependent was not eligible for coverage, CareFirst BlueChoice has the right to recover these amounts from the Subscriber or from the Dependent, at CareFirst BlueChoice's option.

3.2 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 Upon Death of a Subscriber.

3.3 Medical Child Support Orders or Qualified Medical Support Orders. Unless coverage is terminated for non-payment of the premium, a child subject to a MCSO/QMSO of coverage may not be terminated unless written evidence is provided to CareFirst BlueChoice that:

A. The MCSO/QMSO is no longer in effect; or

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

C. The Group has eliminated family member's coverage for all employees; or

D. The Group 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.

3.4 Conversion Privilege. Members whose coverage under this Evidence of Coverage terminates may be eligible for conversion coverage. Eligibility for conversion coverage is described in Section 5 of this Evidence of Coverage.

3.5 Effect of Termination. No benefits will be provided for any services a Member receives 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, except as provided in Section 4.4.

3.6 Reinstatement Requires Application. Coverage will not reinstate automatically, under any circumstances.

SECTION 4
CONTINUATION OF COVERAGE

4.1 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, and insurers, from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

If an eligible employee leaves their job to perform military service, the eligible employee 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 eligible employee's military service, the eligible employee has the right to be reinstated in their group coverage when re-employed, without any waiting periods or preexisting condition exclusions except for service connected illnesses or injuries. If an eligible employee has any questions regarding USERRA, the eligible employee should contact the plan administrator. The plan administrator determines eligible employees and provides that information to CareFirst BlueChoice.

4.2 Additional Right to Continue Group Coverage. A Member has the right to have the present coverage under the Group policy continued for a period of ninety days immediately following the date of the termination of the Member's eligibility, without evidence of insurability, subject to the following requirements:

A. The Member was covered under the Group Contract for at least three months prior to termination;

B. The Member is not:

1. Covered by or eligible for benefits under Medicare;

2. Covered by or eligible for substantially the same level of Hospital, medical, and surgical benefits under state or federal law;

3. Covered by substantially the same level of benefits under any policy, contract, or plan for individuals in a group;

C. The Member was not terminated from this Evidence of Coverage for:

1. Failure to pay the premium;

2. Fraud or material misrepresentation, in enrollment or in the use of services or facilities;

3. Violation of the terms of the prior contract; or,

4. Other good cause as specified in the Evidence of Coverage.

D. The application of this extended coverage is made to the Group policyholder and the total premium for the ninety-day period is paid to the Group policyholder prior to the termination.

E. The premium for continuing the Group coverage shall be at the insurer's current rate applicable to the Group policy.

4.3 Right to Continue Coverage Under Only One Provision. If a Member is eligible to continue coverage under the Group Contract under more than one continuation provision as described above, the Member will receive only one such continuation coverage. The Member may select the continuation coverage of his or her choice.

4.4 Extension of Benefits. In the event of termination of this Evidence of Coverage, any Member who became totally disabled while enrolled under this Evidence of Coverage and who continues to be totally disabled at the date of termination will, upon payment of premium, be entitled to continued coverage under this Evidence of Coverage until the first of the following:

A. The date the Member is, in the judgment of CareFirst BlueChoice, no longer totally disabled;

B. The date that a succeeding carrier elects to provide replacement coverage to that Member without limitation as to the disabling condition; or

C. 180 days following termination.

SECTION 5
CONVERSION PRIVILEGE

5.1 Conversion Privilege.

A. Group Conversion. All Members covered under this Evidence of Coverage whose coverage is terminated for any reason except those listed in Section 5.1.B below are eligible to apply for a Conversion Contract. The Member must apply within 31 days of the termination date.

B. When Conversion Coverage Is Not Provided. A Member is not eligible for a Conversion Contract if the Member:

1. Is eligible for or covered by Medicare;

2. Is eligible for or covered by substantially the same level of Hospital, medical, and surgical benefits under state or federal law;

3. Is covered by substantially the same level of benefits under any policy, contract, or plan for individuals in a group;

4. Has not been continuously covered during the 3 month period immediately preceding the terminating event; or,

5. Was terminated from this Evidence of Coverage for:

a. Failure to pay the premium;

b. Fraud or material misrepresentation in enrollment or in the use of services or facilities;

c. Violation of the terms of the prior contract; or,

d. For other good cause as specified in the Evidence of Coverage.

5.2 Application for Conversion Contracts. A Member who is entitled to continue coverage through a Conversion Contract should contact CareFirst BlueChoice as soon as possible after coverage terminates to request an application form and a schedule of premiums. Benefits under Conversion Contracts may vary from the benefits under this Evidence of Coverage and CareFirst BlueChoice reserves all rights, subject to applicable requirements of law, to determine the form and terms of the conversion contract(s) to be issued.

A. CareFirst BlueChoice must receive a completed application from the Member, including full payment of the first premium, within 31 days after the effective date of termination of this Evidence of Coverage.

B. Conversion Contracts issued under this section will not require evidence of insurability.

C. In no case will enrollment be denied based on the health status of the Member; or, for exercising complaint and grievance rights under this Evidence of Coverage.

5.3 Effective Date of Conversion Contract. A Conversion Contract issued under this section will be effective on the day following the date this Evidence of Coverage terminated or the Member's coverage under this Evidence of Coverage terminated.

SECTION 6
COORDINATION OF BENEFITS ("COB")

6.1 Coordination of Benefits ("COB")

A. Applicability

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

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

   a. shall not be coordinated when, under the order of determination rules, this CareFirst BlueChoice Plan determines its benefits before another Plan; but

   b. may be coordinated when, under the order of determination rules, another Plan determines its benefits first. The coordination is explained in Section 6.1.D.2. below.

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

CareFirst BlueChoice Plan means this Evidence of Coverage.

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

Plan means any health insurance policy issued on a group basis, including those of a nonprofit health service Plan, and those of commercial group and blanket 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. A policy issued on an individual basis, including an individually underwritten and issued, guaranteed renewable, specified disease policy;

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

3. Coverage regulated by a motor vehicle reparation law;

4. The first one-hundred dollars ($100) per day of a Hospital indemnity contract; 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 BlueChoice Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

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

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

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

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

C. Order of Determination Rules

1. General

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

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

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

2. Rules

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

a. Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare

beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

i. Secondary to the Plan covering the person as a dependent, and

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

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

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

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

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

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

ii. For a dependent child whose parents are separated, divorced, or are not living together:

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

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

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

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

b) The Plan of the Spouse of the parent with the custody of the child;

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

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

iii. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules set forth in 1) and 2) of this paragraph as if those individuals where parents of the child.

c. Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan 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.

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

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

ii. Second, the benefits under the continuation coverage.

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

e. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered 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 BlueChoice Plan

1. When this Section Applies

This section applies when, in accordance with the prior section, Order of Determination Rules, this CareFirst BlueChoice Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst BlueChoice Plan may be coordinated under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

2. Coordination in this CareFirst BlueChoice Plan's Benefits

When this CareFirst BlueChoice Plan is the Secondary Plan, the benefits under this CareFirst BlueChoice Plan *may* be coordinated so that the total benefits that would be payable or provided by all the other Plans do not exceed one hundred

percent (100%) of the total Allowable Expenses. If the benefits of this CareFirst BlueChoice Plan are coordinated, each benefit is coordinated in proportion. It is then charged against any applicable benefit limit of this CareFirst BlueChoice Plan.

E. Right to Receive and Release Needed Information

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

F. Facility of Payment

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

G. Right of Recovery

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

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

2. Insurance companies, or,

3. Other organizations.

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

6.2 Medicare Eligibility

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

A. Coverage Secondary to Medicare

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

B. Medicare as Primary

1. When benefits for Covered Services are paid by Medicare as primary, this CareFirst BlueChoice Plan will not duplicate those payments. When CareFirst BlueChoice coordinates the benefits with Medicare, CareFirst BlueChoice's payments will be based on the Medicare allowance (if the provider is a

participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare).

2. Benefits under this CareFirst BlueChoice Plan will be coordinated as described above to the extent a benefit would have been provided or payable under Medicare if the Member had diligently sought to establish his or her right to such benefits. Members shall agree to complete and submit to Medicare, CareFirst BlueChoice and/or Contracting Providers all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

SECTION 7
GENERAL PROVISIONS

7.1 Claims Submission and Payment

A. Claims Forms

1. CareFirst BlueChoice does not require a written notice of a claim. A Member may request a claims form by writing or calling CareFirst BlueChoice. CareFirst BlueChoice, upon receipt of a notice of a claim, will send the Member claims forms. If claim forms are not sent within fifteen (15) days after CareFirst BlueChoice's receipt of the notice, the Member shall be deemed to have complied with the requirements of this Evidence of Coverage as to proof of loss upon submitting, within the time fixed in the Evidence of Coverage for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

2. When a Dependent child subject to a Medical Child Support Order or a Qualified Medical Support Order does not reside with the Subscriber, CareFirst BlueChoice 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 provider of a Covered Service to submit a claim without the approval of the Subscriber;

   c. Provide benefits directly to:

      i. The non-insuring, custodial parent;

      ii. The provider of the Covered Services; or

      iii. The appropriate child support enforcement agency of any State or the District of Columbia.

B. Proof of Loss

Written proof of loss must be furnished to CareFirst BlueChoice within 180 days after the date of the loss. Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

CareFirst BlueChoice 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 BlueChoice before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst BlueChoice deems necessary to process the claims. CareFirst BlueChoice provides forms for this purpose.

C. Time of Payment of Claims. Benefits payable under this Evidence of Coverage will be paid within sixty (60) days after receipt of written proof of loss.

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

7.2 Payment of Claims. Payments for Covered Services will be made by CareFirst BlueChoice directly to Contracting Physicians and Contracting Providers. If a Member receives Covered Services from Non-Contracting Providers, CareFirst BlueChoice reserves the right to pay either the Member or the provider and such payment shall, in either case, constitute full and complete satisfaction of CareFirst BlueChoice's obligation. If the Member has paid the health care provider for services rendered, benefits will be payable to the Member.

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

7.4 Delivery of Evidence of Coverage. Unless CareFirst BlueChoice makes delivery directly to the Member, CareFirst BlueChoice will provide to the Group, for delivery to each Member, a statement that summarizes the essential features of the coverage and indicates to whom benefits under the Evidence of Coverage are payable. Only one statement will be issued for each family unit, except in the instance of an eligible child who is covered due to a MCSO/QMSO. In that instance, an additional Evidence of Coverage will be delivered to the custodial parent, upon request.

7.5 No Assignment. A Member cannot assign any benefits or payments due under the Evidence of Coverage to any person, corporation or other organization, except as specifically provided by this Evidence of Coverage or as required by law.

A. When a Member receives Medically Necessary ambulance services from a Non-Contracting ambulance services provider, CareFirst BlueChoice will issue payment directly to the Member. However, for these providers, the Member may elect to assign benefits to the person providing such services by notifying CareFirst BlueChoice in writing of the assignment. Prior authorization of the ambulance services is not required. For the purposes of this section, ambulance service means the transportation of any person requiring resuscitation or emergency relief or where human life is endangered.

B. The Member may elect to assign benefits for Medically Necessary Covered Services to non-participating dentists or non-participating oral surgeons providing such services by notifying CareFirst BlueChoice in writing of the assignment.

C. CareFirst BlueChoice must be presented with the assignment of benefits in writing. Any assignment by the Member that does not comply with the terms as stated above will be void.

7.6 Events outside of the CareFirst BlueChoice's Control.

A. An event outside of the control of CareFirst BlueChoice refers to a natural disaster, epidemic, complete or partial destruction of facilities, disability of a significant part of CareFirst BlueChoice or Contracting Provider staff, war (whether declared or not), riot, civil insurrection or any similar event over which CareFirst BlueChoice cannot exercise influence or control.

B. When an event outside the control of CareFirst BlueChoice affects the operations of CareFirst BlueChoice or Contracting Providers, CareFirst BlueChoice and Contracting Providers will use their best efforts to continue to provide and arrange benefits and

services to Members under this Evidence of Coverage, taking into account the impact of the event on facilities and personnel and the extent to which the services required by the Member are Medically Necessary and urgently needed.

C. If CareFirst BlueChoice and Contracting Providers are unable to provide or arrange benefits under Section 7.6.B in a reasonable manner and within a reasonable time of the Member's request, coverage will be provided for covered services obtained from any physician, Hospital or provider of the Member's choice. The Member or the provider will be reimbursed for the cost of such services up to the benefit limits of this Evidence of Coverage if, and to the extent, CareFirst BlueChoice determines:

1. That the services would have been covered under this Evidence of Coverage if provided or arranged by a Contracting Provider;

2. That obtaining these services from Contracting Providers was impossible, impractical or would have entailed a medically unacceptable delay; and

3. That the services were Medically Necessary and urgently needed.

D. Except as provided in Section B and C above, neither CareFirst BlueChoice nor any Contracting Provider will have any liability or obligation for delay or failure to provide or arrange any services or benefits when the delay or failure is caused by an event outside CareFirst BlueChoice's control.

7.7 Provider and Services Information. Listings of current Contracting Providers will be made available to Members at the time of enrollment. Updated listings are available to the Group and Members upon request.

7.8 Selection of a Primary Care Physician.

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

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

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

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

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

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

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

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

D. If a change in Primary Care Physicians is required, advance written notice will be given to the Member. The change is effective upon written notice to the Member. However, the Member may request a review of the action under the Benefit Determinations and Appeals described in Attachment A.

E. If a Member is required to change to another Primary Care Physician due to any of the circumstances described in Section 7.8.C, and there is a recurrence of the same or a similar situation with another Primary Care Physician, CareFirst BlueChoice may terminate the Member's coverage upon 31 days' written notice.

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

A. Possession of an identification card confers no right to benefits under the Evidence of Coverage.

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

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

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

7.11 Member Privacy. CareFirst BlueChoice 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 BlueChoice will not provide to the Group 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.

7.12 Relationship of CareFirst BlueChoice to Contracting Physicians and Contracting Providers. Contracting Physicians and Contracting Providers are independent contractors or organizations and are related to CareFirst BlueChoice by contract only. Contracting Physicians and Contracting Providers are not employees or agents of CareFirst BlueChoice and are not authorized to act on behalf of or obligate CareFirst BlueChoice with regard to interpretation of the terms of this Evidence of Coverage, including eligibility of Members for coverage or entitlement to benefits. Contracting Physicians maintain a physician-patient relationship with the Member and are solely responsible for the professional services they provide. CareFirst BlueChoice is not responsible for any acts or omissions, including those involving malpractice or wrongful death of Contracting Physicians, Contracting Providers or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

7.13 CareFirst BlueChoice's Relationship to the Group. The Group is not an agent or representative of CareFirst BlueChoice and is not liable for any acts or omissions by CareFirst BlueChoice or any

Contracting Provider. CareFirst BlueChoice is not an agent or representative of the Group and is not liable for any act or omission of the Group.

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

7.15 Rights under Federal Law. This Evidence of Coverage may be subject to federal law including the Employee Retirement Income Security Act of 1974, as amended (" ERISA"), the Consolidate Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), the Uniformed Services Employment and Reemployment Rights Act ("USERRA") and/or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") the Group is the "Plan Administrator" for the purposes of ERISA and/or COBRA. As the Plan Administrator, it is the Group's responsibility to provide the Member with certain information, including access to, and copies of, plan documents describing the Member's benefits and rights to coverage under the Group health plan. Such rights include the right to continue coverage upon the occurrence of certain "qualifying events". Under HIPAA, Disclosures of Creditable Coverage will be provided by CareFirst BlueChoice and/or the Group. In any event, the Member should check with the Group to determine the Member's rights under ERISA, COBRA, USERRA and/ or HIPAA, as applicable.

The Member should confer with the Group to determine what rights, if any, are available to the Member under these laws.

7.16 Rules for Determining Dates and Times. The following rules will be used when determining dates and times under this Evidence of Coverage:

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

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

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

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

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

7.17 Notices.

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

B. To CareFirst BlueChoice. When notice or payment is sent to CareFirst BlueChoice, it must be sent by first class mail to CareFirst BlueChoice, Inc., 840 First Street, NE, Washington, DC 20065.

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

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

7.18 Regulation of CareFirst BlueChoice. CareFirst BlueChoice is subject to regulation in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 of the Virginia Code, and the Virginia Department of Health pursuant to Title 32.1 of the Virginia Code.

7.19 Evidence of Coverage Binding on Members. This Evidence of Coverage can be amended, modified or terminated in accordance with any provision of this Evidence of Coverage or by mutual agreement between CareFirst BlueChoice and the Group. This does not require the consent or concurrence of Members. By electing coverage under this Evidence of Coverage, or accepting benefits under this Evidence of Coverage, each Member agrees (and if the Member is legally incapable of contracting, the representative of such Member agrees) to all the terms, conditions and provisions of this Evidence of Coverage.

7.20 Amendment Procedure.

Regardless of when the amendment is received, this Evidence of Coverage is considered to be automatically amended upon the Contract Renewal Date, unless otherwise mandated, to conform to any applicable changes to state or federal law. If an amendment is mandated by state or federal law, it will be deemed accepted.

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

7.21 Payment of Contributions. The Group Contract is issued to the Group on a contributory basis in accordance with the Group's policies. The Group has agreed to collect from Members any contributory portion of the premium and pay to CareFirst BlueChoice the premium as specified in the Group Contract for all Members.

7.22 Certificate of Creditable Coverage. CareFirst BlueChoice will furnish a written certificate of creditable coverage via first-class mail.

A. Termination of CareFirst BlueChoice 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 BlueChoice 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.

B. Individuals for Whom Certificate Must be Provided; Timing of Issuance

1. Issuance of Automatic Certificates

a. Qualified Beneficiaries Upon A Qualifying Event

In the case of an individual entitled to elect COBRA continuation coverage, CareFirst BlueChoice 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 BlueChoice 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.

b. Other Individuals When Coverage Ceases

In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, CareFirst BlueChoice will provide the certificate at the time the individual ceases to be covered under this Group Contract. CareFirst BlueChoice 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 in denied due to the operation of the lifetime limit.

c. 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 BlueChoice will provide the certificate at the time the individual's coverage under the COBRA continuation coverage ceases. CareFirst BlueChoice will provide the certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of Premiums). CareFirst BlueChoice will provide the certificate regardless of whether the individual has previously received a certificate under paragraph B.1.a of this section.

2. Any Individual Upon Request

CareFirst BlueChoice 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 BlueChoice will provide the certificate by the earliest date that CareFirst BlueChoice, acting in a reasonable and prompt fashion, can provide the certificate. CareFirst BlueChoice will provide the certificate regardless of whether the individual has previously received a certificate under paragraph B.1.b., paragraph 2 or B. 1.b of this section.

C. 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.

SECTION 8
SERVICE AREA

CareFirst BlueChoice's Service Area means the geographic area within which CareFirst BlueChoice has arranged for the provision of health care services to be generally available and readily accessible to Members. CareFirst BlueChoice will provide the Member with a specific description of the Service Area at the time of enrollment or attached to this Evidence of Coverage.

The Service Area is as follows: the District of Columbia; the state of Maryland; and the following Virginia counties and cities - Arlington, Alexandria, Fairfax, City of Fairfax, Falls Church, Prince William, Manassas, Manassas Park, Loudoun and Leesburg. CareFirst BlueChoice may amend the defined Service Area at any time by notifying the contract holder.

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

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT A

BENEFIT DETERMINATIONS AND APPEALS

INFORMATION REGARDING THE VIRGINIA BUREAU OF INSURANCE, THE OFFICE OF THE MANAGED CARE OMBUDSMAN, and OFFICE OF LICENSURE AND CERTIFICATION

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 CareFirst BlueChoice, Inc. (CareFirst BlueChoice), which afford CareFirst BlueChoice Members recourse pertaining to denials and reductions of claims for benefits by CareFirst BlueChoice.

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 CareFirst BlueChoice procedures.

A. DEFINITIONS

Adverse Determination means, as used in this attachment, the following:

1. 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 this Plan. An Adverse Determination includes a Rescission.

2. 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 Cosmetic, Experimental or Investigational, or not Medically Necessary or appropriate.

Health Care Provider means, as used in this attachment, a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Pre-Service Claim means, as used in this attachment, any claim for a benefit when the receipt of the benefit, in whole or in part, is conditioned on the prior approval of the service in advance by CareFirst BlueChoice.

These are services that must be "preauthorized" or "precertified" by CareFirst BlueChoice under the terms of the Member's contract.

Post-Service Claim means, as used in this attachment, any claim for a benefit that is not a Pre-Service Claim.

Rescission means, as used in this attachment, 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/Emergent Care means, as used in this attachment, a Pre-Service Claim or concurrent care decision for care or treatment with respect to which the application of the time periods for making non-Urgent/Emergent Care determinations:

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

2. In the opinion of a Health Care Provider with knowledge of the Member's condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim involves Urgent/Emergent Care is to be determined by an individual acting on behalf of CareFirst BlueChoice applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If a Health Care Provider with knowledge of the Member's condition determines that a claim involves Urgent/Emergent Care then CareFirst BlueChoice will treat the claim as one that involves Urgent/Emergent Care.

B. BENEFIT DETERMINATIONS

1. A Request for Urgent/Emergent Care Coverage. When the Member or authorized representative requests a pre-service determination regarding Urgent/Emergent Care, then CareFirst BlueChoice will notify the Member or authorized representative of the benefit determination (whether adverse or not) as soon as possible, taking into account the exigencies, the earlier of 24 hours after CareFirst BlueChoice's receipt of the information needed to make the benefit determination, or 72 hours after receipt of the request for coverage.

   If a Member fails to provide sufficient information for CareFirst BlueChoice to determine whether benefits are covered or payable, CareFirst BlueChoice will notify the Member as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claims. 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. CareFirst BlueChoice will notify the Member of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

   a. CareFirst BlueChoice's receipt of the specified information, or

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

2. Pre-Service Claims. In the case of a Pre-Service Claim, CareFirst BlueChoice shall notify the Member of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the circumstances, but no later than 15 days after receipt of the claim.

   This period may be extended one time by CareFirst BlueChoice for up to 15 days, provided that such an extension is necessary due to matters beyond the control of CareFirst BlueChoice and CareFirst BlueChoice 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 CareFirst BlueChoice expects to render a decision. 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 will have at least 45 days from receipt of the notice within which to provide the specified information.

In the case of a failure by a Member or authorized representative to follow Plan 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 or authorized representative, as appropriate, as soon as possible, but not later than 5 working days following the failure. Notice will be sent within 24 hours in the case of a failure to file a claim involving Urgent/Emergent Care. Notification may be oral, unless written notification is requested by the Member or authorized representative. This paragraph shall apply only in the case of a communication:

a. By a Member or authorized representative that is received by CareFirst BlueChoice or its authorized agent customarily responsible for handling benefit matters; and,

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

3. Post-Service Claims. In the case of a Post-Service Claim, CareFirst BlueChoice shall notify the Member of an Adverse 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 by CareFirst BlueChoice for up to 15 days, provided that CareFirst BlueChoice both determines that such an extension is necessary due to matters beyond the control of CareFirst BlueChoice 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 CareFirst BlueChoice expects to render a decision. 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.

4. Concurrent Care Decisions. If CareFirst BlueChoice has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

a. CareFirst BlueChoice will notify the Member of any reduction or termination of a course of treatment (other than by a change in the Group's coverage by amendment or termination of coverage) before the end of such period of time or number of treatments and at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review before the benefit is reduced or terminated.

b. 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/Emergent Care will be decided as soon as possible, taking into account the exigencies. CareFirst BlueChoice will notify the Member of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made to CareFirst BlueChoice at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

5. Rescissions. If CareFirst BlueChoice has made an Adverse Determination that is a Rescission, CareFirst BlueChoice shall provide 30 days advance written notice to any covered person who would be affected by the proposed Rescission.

6. Calculating Time Periods. For purposes of this Part B, the period of time within which an Adverse Determination is required to be made shall begin at the time a claim is filed in accordance with Plan procedures. This time is counted regardless to whether all the information necessary to make a benefit determination accompanies the filing. In the event

that a period of time is extended 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.

7. Provider Inquiries and Reconsideration. As a part of CareFirst BlueChoice's utilization review process, a Health Care Provider may request a reconsideration of an Adverse Determination that is not a Rescission. Reconsideration shall be made by a physician advisor, peer of the treating Health Care Provider, or a panel of other appropriate Health Care Providers with at least one physician advisor or peer of the treating Health Care Provider on the panel.

   The Health Care Provider will be notified of the decision within 2 business days after CareFirst BlueChoice receives all information necessary to complete the review. The notice will include the criteria used and the clinical reason for the Adverse Determination, the alternate length of treatment of the alternate treatment setting or settings, if any, that CareFirst BlueChoice deems to be appropriate, and the opportunity for an appeal as explained below. The reconsideration shall be rendered and the decision provided to the treating Health Care Provider and the Member in writing within 10 working days of receipt of the request for reconsideration.

   This is not a necessary step in the appeals process. A member can appeal an Adverse Determination regardless of whether the Health Care Provider elected to request a reconsideration.

C. INTERNAL APPEAL PROCEDURE

1. An appeal must be filed within 180 days from the date of receipt of the written notice of any Adverse Determination.

2. A Member or authorized representative should first contact CareFirst BlueChoice about a denial of benefits. CareFirst BlueChoice can provide information and assistance on how to file an appeal. All appeals filed should be in writing, except with respect to claims involving Urgent/Emergent Care, which may be submitted orally or in writing.

3. The Member or authorized representative may submit written comments, documents, records, and other information relating to a claim for benefits.

4. Expedited Appeal for Urgent/Emergent Care. The appeal decision for Urgent/Emergent Care claim shall be made as soon as possible but no later than the earlier of 24 hours after CareFirst BlueChoice's receipt of the necessary information to make the decision regarding request for coverage, or 72 hours after receipt of the request for coverage. An appeal decision for Urgent/Emergent Care claim can be made in writing or orally. A Member that is not satisfied with the outcome of an expedited appeal may have the right to an external review as described below under Complaints To The Virginia Bureau Of Insurance and Assistance from the Office of the Managed Care Ombudsman, and the Office of Licensure and Certification.

5. 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. A document, record, or other information shall be considered relevant to a Member's claim if it:

   a. Was relied upon in making the Adverse Benefit Determination;

   b. Was submitted, considered, or generated in the course of making the Adverse Determination, without regard to whether such document, record, or other information was relied upon in making the Adverse Determination; or,

c. Demonstrates compliance with the administrative processes and safeguards designed to ensure and verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, CareFirst BlueChoice provisions have been applied consistently with respect to similarly situated members.

6. A Member who would like to file an appeal may contact CareFirst BlueChoice at the address and toll free number located on their Member ID Card; or forward an appeal and any applicable documentation to:

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

7. Timing of Plan Responses. The time limits for responding to an appeal will begin at the time an appeal is filed in accordance with these procedures, without regard to whether all the information necessary to make a decision is initially included. CareFirst BlueChoice will make an appeal decision and written notification will be sent:

a. Within 30 days after receipt of the appeal for a case involving a Pre-Service Claim; or,

b. Within 60 days after receipt of the appeal for a case involving a Post-Service Claim.

In the case of an expedited appeal regarding a claim relating to a prescription for the alleviation of cancer pain, the appeal decision shall be made as soon as possible but no later than 24 hours after receipt of the appeal.

8. When More Information is Needed for a Decision. CareFirst BlueChoice will send notice within 5 working days of the receipt of the appeal that it cannot proceed with its review unless the additional information is provided. CareFirst BlueChoice will assist in gathering the necessary information. The response deadlines described above may be extended one time by CareFirst BlueChoice for up to 15 days, provided that CareFirst BlueChoice both:

a. Determines that such an extension is necessary due to matters beyond the control of CareFirst BlueChoice; and,

b. 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 CareFirst BlueChoice expects to render a decision.

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.

In the event that a period of time is extended due to a Member's failure to submit necessary information, the period for responding to an appeal 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.

The Member must agree to this extension in writing. The Member will be asked to sign a consent form.

D. FULL AND FAIR REVIEW

CareFirst BlueChoice will provide a review on appeal that:

1. Provides the Member with an opportunity to submit written comments, documents, records, and other information relating to the appeal for the reviewers to consider when reviewing the appeal.

2. Upon request, gives the Member reasonable access to and free of charge copies of all documents, records and other information relevant to the covered person's request for benefits;

3. Takes 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;

4. Does not afford deference to the initial Adverse Determination and is conducted by an appropriate named fiduciary of CareFirst BlueChoice who is neither the individual who made the Adverse Determination that is subject to the appeal, nor the subordinate of such individual;

5. In deciding an appeal, an Adverse Determination that is based in whole or in part on a judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment;

6. Provides for the identification of medical or vocational experts whose advice was obtained on behalf of CareFirst BlueChoice in connection with a Member's Adverse Determination, without regard to whether the advice was relied upon in making the Adverse Determination; and,

7. The health care professional engaged for purposes of a consultation is an individual who is neither an individual who was consulted in connection with the Adverse Determination, nor the subordinate of any such individual.

8. In addition to the requirements of this section regarding full and fair review, all appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

A Member that is not satisfied with the outcome of an appeal may have the right to an external review as described below.

E. EXTERNAL REVIEW

1. The Member has the right to file a request for an external review of an Adverse Determination or an appeal decision on an Adverse Determination with the Commission. External review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness.

   Virginia Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23218
   Toll-free within Virginia: 1-800-552-7945
   804-371-9691

   When filing a request for an external review, 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 external review.

2. The appeal forms requesting the review must be submitted to the Bureau of Insurance within 120 days of the date the Member receives the Adverse Decision.

F. DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEAL PROCESS

In the case of a plan that fails to adhere to the minimum requirements for employee benefit plan procedures relating to claims, the Member is deemed to have exhausted the internal claims and appeals processes of paragraph C and D herein. Accordingly the Member may initiate an external review under paragraph F of this section, as applicable. The Member is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a Member chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

G. COMPLAINTS TO THE VIRGINIA BUREAU OF INSURANCE AND ASSISTANCE FROM THE OFFICE OF THE MANAGED CARE OMBUDSMAN, AND OFFICE OF LICENSURE AND CERTIFICATION

1. In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the address and toll free telephone number located on your Member ID Card; or at the following address and telephone number:

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

2. If you have been unable to contact or obtain satisfaction from CareFirst BlueChoice or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

   Virginia Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23218
   Toll-free within Virginia: 1-800-552-7945
   804-371-9691

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

3. **If a Member has any questions regarding an appeal concerning the health care services that have been provided and which have not been satisfactorily addressed by CareFirst BlueChoice, a Member may contact the Office of the Managed Care Ombudsman for assistance.**

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll-free: 1-877-310-6560
804-371-9032
Email: Ombudsman@scc.virginia.gov

Information regarding the Virginia Bureau of Insurance or the Office of the Managed Care Ombudsman may be found by accessing the State Corporation Commission's web page at: http://www.scc.virginia.gov.

Members may also contact the Office of Licensure and Certification Complaint Unit for assistance with the quality of care complaints, in writing:

Complaint Intake
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1463
Toll free: 1-800-955-1819
Richmond metropolitan area: 804-367-2106
Fax: 804-527-4503
E-mail: mchip@vdh.virginia.gov

CareFirst BlueChoice, Inc.

Chester E. Burrell
President and Chief Executive Officer

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

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT B
IN-NETWORK DESCRIPTION OF COVERED SERVICES

The services described herein are eligible for coverage under the Evidence of Coverage. CareFirst BlueChoice 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 BlueChoice or the Member will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists important information about any Deductibles, Out-of- Pocket Maximum and other features that affect Member coverage, including specific benefit limitations.

CareFirst BlueChoice, Inc.

Chester E. Burrell
President and Chief Executive Officer

SECTION 1
OUTPATIENT AND OFFICE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In Contracting Physicians' offices or in other Contracting Provider facilities.	Coverage for the services listed below. The coverage is subject to the limitations, if	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

1.1 Covered Outpatient Medical Services. Members are entitled to benefits for the Covered Services listed below when provided by Contracting Providers in accordance with the requirements of this Description of Covered Services.

A. Office visits, medical care, urgent care, surgery and consultations, with a Primary Care Physician and other Contracting Providers. This includes a history and baseline examination after enrollment.

B. Diagnostic Procedures.

C. Laboratory Tests and X-ray Services rendered by designated Contracting Providers, whether ordered by a Contracting Provider or a Non-Contracting Provider.

D. Preventive Services.

In addition to the benefits listed in this provision, CareFirst BlueChoice 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 BlueChoice preventive guidelines.

1. Cancer Screening. Benefits are provided for cancer screening, including:

a. Prostate cancer examinations. Benefits are available when rendered in accordance with the most current American Cancer Society's guidelines and include a medically recognized diagnostic examination, digital rectal exams and the prostate-specific antigen (PSA) tests.

b. Colorectal cancer screening. Benefits are available for a medically recognized diagnostic examination in accordance with the most recently published recommendations of the American College of Gastroenterology, in consultation with the most current American Cancer Society guidelines appropriate for age, family history and frequency and shall include:

i. Annual fecal occult blood test;

ii. Flexible sigmoidoscopy;

iii. Colonoscopy; and,

iv. Radiologic imaging.

c. A minimum of one annual pap smear, including tests performed using FDA approved gynecological cytology screening technologies. Additional Medically Necessary pap smear tests, as determined appropriate by CareFirst BlueChoice.

d. Low dose mammography screenings to determine the presence of occult breast cancer as determined to be appropriate by a Contracting Physician. Benefits are available for one screening:

i.. for Members who are 35 through 39 years old;

ii. every two years for Members who are 40 through 49 years old; and,

iii. every year for Members 50 years old and older.

2. Immunizations. Coverage is provided in accordance with accepted medical practice. Immunizations required solely for travel are not covered.

3. Well child preventive care and pediatric services in accordance with the most recent guidelines of the American Academy of Pediatrics.

4. Adult preventive care.

E. Allergy Testing and Treatment. Benefits are available for allergy testing and treatment, including administration of injections and allergy serum.

F. Obstetric and Gynecological Care. Benefits include health care services incidental to and rendered during an annual visit.

G. Eye Examinations. Eye examinations for the diagnosis and treatment of a medical condition.

H. Routine Hearing Screening. Coverage for children age 17 and under.

I. Rehabilitation Services. Coverage shall include Physical Therapy, Occupational Therapy and Speech Therapy for the treatment of individuals who have sustained an illness or injury that CareFirst BlueChoice determines to be subject to improvement.

The goal of rehabilitation services is to return the individual to his/her prior skill and functional level. Occupational Therapy, Physical Therapy and Speech Therapy are covered, as defined below, subject to any limitations as stated in the Schedule of Benefits.

1. Definitions.

a. Occupational Therapy (OT) 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. Occupational therapy services do not include the adjustment or manipulation of any of the osseous structures of the body or spine.

b. Speech Therapy (ST) means the treatment of communication impairment and swallowing disorders. Speech Therapy services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation, including cognitive rehabilitation.

c. Physical Therapy (PT) includes the short term treatment described below that can be expected to result in a significant improvement of a Member's condition within a period of 90 days. Physical Therapy means 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.

2. Prior authorization is not required for Physical Therapy, Occupational Therapy, or Speech Therapy services or for any other service provided by the same provider on the same day as these services.

J. Radiation Therapy. Prior authorization is required for outpatient radiation therapy.

K. Chemotherapy.

L. Family Planning Services. Coverage includes:

1. Contraceptive counseling;

2. Depo-Provera, Norplant, intra-uterine devices and any Medically Necessary insertion, removal, or examination associated with the use of any contraceptive drug or device that is approved by the FDA for use as a contraceptive.

M. Renal Dialysis. Coverage will be provided for Medically Necessary hemodialysis and peritoneal dialysis for chronic kidney conditions.

N. Early Intervention Services.

1. Definitions

a. Early Intervention Services means Medically Necessary Speech Therapy, Occupational Therapy, Physical Therapy and assistive technology services and devices for Dependents from birth to age three.

b. Medically Necessary Services are services that are designed to help an individual attain or retain the capability to function age-appropriately within his or her environment and shall include services that enhance functional ability without effecting a cure for Dependents from birth to age three.

c. 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.

2. Except as provided below, benefits will not be provided for Habilitative Services. Benefits for Physical Therapy, Occupational Therapy and Speech Therapy in Section 1.1I. do not include benefits for Habilitative Services.

3. Benefits will be provided for Medically Necessary Early Intervention Services for Dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20

U.S.C. § 1471 et seq.).

a. Coverage for Early Intervention Services is limited to $5,000 per Member per Benefit Period.

b. Services and devices that are Experimental/Investigational will not be covered.

c. Prior authorization is not required for Early Intervention Services or for any other service provided by the same provider on the same day as these services.

d. The Member is required to submit an individualized family service plan or plan of treatment to CareFirst BlueChoice to receive benefits for Early Intervention Services.

O. Blood and Blood Products.

1. Administration of infusions and transfusions.

2. Blood and blood products (including derivatives and components) that are not replaced by or on behalf of the Member.

P. Newborn Coverage. Coverage shall include:

1. Medically Necessary routine newborn visits, including admission and discharge exams;

2. Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Benefits shall also include inpatient and outpatient dental, oral surgical, and orthodontic services which are Medically Necessary for the treatment of diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and

3. All necessary audiological examinations provided pursuant to the Virginia Hearing Impairment Identification and Monitoring System, using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Benefits include any follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

Q. Cancer Pain Medication. Benefits for cancer pain medication prescribed by the provider in excess of the FDA recommended dosage will be provided, so long as the cancer pain medication is:

1. Medically Necessary;

2. Prescribed for intractable cancer pain;

3. Approved by the FDA for use in the treatment of cancer pain; and;

4. Prescribed in compliance with the Virginia Code.

R. Infusion drugs. Services must be authorized or approved by CareFirst BlueChoice.

S. Spinal Manipulation Services. Coverage shall be provided for Medically Necessary

spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a licensed chiropractor, doctor of osteopathy (D.O.) or other eligible practitioner who is a Contracting Provider. Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.

1. Prior authorization is not required for spinal manipulation services or for any other service provided by the same provider on the same day as these services.

T. Limited Service Immediate Care. Coverage is provided for treatment of common conditions or ailments, which require rapid and specific treatment that can be administered in a limited duration of time. Limited Service Immediate Care services are non-emergency and non-urgent services. Services are provided in Limited Service Immediate Care Centers, which are mini-medical office chains typically staffed by nurse practitioners with an on-call physician. Examples of common ailments for which a reasonable, prudent layperson who possesses an average knowledge of health and medicine would seek Limited Service Immediate Care, include but are not limited to: ear, bladder, and sinus infections; pink eye; flu; and strep throat.

U. Cardiac Rehabilitation. Benefits are provided to Members who have been diagnosed with significant cardiac disease, as defined by CareFirst BlueChoice, or, who have suffered a myocardial infarction or have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation, as defined by CareFirst BlueChoice. Coverage is provided for all Medically Necessary services, as determined by CareFirst BlueChoice. Services must be provided at a CareFirst BlueChoice approved place of service equipped and approved to provide cardiac rehabilitation.

1. Prior authorization is not required for cardiac rehabilitation.

2. Benefits will not be provided for maintenance programs.

V. Pulmonary Rehabilitation. Benefits are provided to Members who have been diagnosed with significant pulmonary disease, as defined by CareFirst BlueChoice, or, who have undergone certain surgical procedures of the lung, as defined by CareFirst BlueChoice. Coverage is provided for all Medically Necessary services, as determined by CareFirst BlueChoice. Services must be provided at a CareFirst BlueChoice approved place of service equipped and approved to provide pulmonary rehabilitation.

1. Prior authorization is not required for pulmonary rehabilitation.

2. Benefits will not be provided for maintenance programs.

3. Benefits are provided for one pulmonary rehabilitation program per lifetime.

1.2 Outpatient Surgical Care. Benefits are available for the following services in a Hospital or in an ambulatory surgical facility, in connection with a covered surgical procedure. Services provided to the Member as an outpatient in a Hospital must receive prior authorization from CareFirst BlueChoice.

A. Use of operating room and recovery room.

B. Use of special procedure rooms.

C. Anesthesia services and supplies.

D. Diagnostic procedures, laboratory tests and x-ray services.

E. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

F. Medical and surgical supplies.

G. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administrations of infusions are covered.

1.3 Organ and Tissue Transplants.

A. Coverage is provided for all Medically Necessary, non-Experimental/Investigational bone marrow, solid organ transplant, and other non-solid organ transplant procedures. Medical Necessity is determined by CareFirst BlueChoice. Prior authorization must be obtained from CareFirst BlueChoice.

B. Covered services include the following:

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

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

3. Cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of 18 years) to and from the site of the transplant if approved by CareFirst BlueChoice. This benefit is available only when the covered transplant is not performed in the Service Area.

4. There is no limit on the number of re-transplants that are covered.

5. If the Member is the recipient of a covered organ/tissue transplant, CareFirst BlueChoice will cover the Donor Services (as defined below) to the extent that the services are not covered under any other health insurance plan or contract.

Donor Services consist of services covered under the Evidence of Coverage which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure which are directly related to donating the organ or tissue.

6. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant. The cost of these drugs will not be counted towards any prescription drug benefit maximum under any rider attached to the Evidence of Coverage.

Benefits are only available upon receipt of a written request from a physician and if determined to be Medically Necessary, non-Experimental/Investigational, and appropriate by CareFirst BlueChoice given due consideration to the general health status, age, and prognosis for significant improvement of the general health status of the Member following the transplant procedure. The physician must certify that alternative procedures, services, or courses of treatment would not be effective in the treatment of the Member's condition.

1.4 High Dose Chemotherapy/ Bone Marrow or Stem Cell Transplant. Benefits will be provided for high dose chemotherapy bone marrow or stem cell transplant treatment that is not Experimental/ Investigational, when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologists experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell

transplants.

1.5 Clinical Trials. Benefits for Patient Cost to a Member in a Clinical Trial will be provided in accordance with the terms below regardless of whether rendered inside or outside of the Service Area. These Clinical Trial services may be provided by Contracting or Non-Contracting Providers. Prior authorization from CareFirst BlueChoice is required for all services.

A. Terms.

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:

1. The National Cancer Institute Clinical Cooperative Group;

2. The National Cancer Institute Community Clinical Oncology Program;

3. The AIDS Clinical Trials Group; and,

4. 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 service that is incurred as a result of the treatment being provided under the Clinical Trial. Patient Cost does not include:

1. The cost of an Experimental/Investigational drug or device;

2. The cost of non-health care services that a Member may be required to receive under the Clinical Trial;

3. Costs associated with managing the research associated with the Clinical Trial; or

4. Costs that would not be covered under the Evidence of Coverage for non-investigational treatments.

B. Patient Cost related to a Clinical Trial will be covered if the Member's participation in the Clinical Trial is the result of:

1. Treatment studies provided for a life-threatening condition; or

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

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

1. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for treatment, prevention and early detection of cancer; or

2. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for treatment, prevention and early detection of any other life threatening condition;

3. The treatment is being provided in a Clinical Trial approved by:

   a. One of the National Institutes of Health, such as the National Cancer Institute (NCI); or

   b. An NIH Cooperative Group or an NIH Center; or

   c. The FDA in the form of an investigational new drug application; or

   d. The federal Department of Veterans Affairs; or,

   e. 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;

4. The facility and personnel providing the treatment are capable of doing so by virtue of their:

   a. Experience;

   b. Training; and,

   c. Volume of patients treated to maintain expertise;

5. There is no clearly superior, non-investigational treatment alternative; and,

6. 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.

7. Services have been authorized by CareFirst BlueChoice.

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

1.6 Maternity Benefits.

A. Maternity Services. Benefits are provided for all female Members including:

1. Obstetrical care, prenatal, delivery, postnatal care;

2. Coverage for a Hospital stay;

3. Coverage for care rendered by a CareFirst BlueChoice approved licensed birthing center; and

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

B. Postpartum Home Visits. See Section 4.5.B., Home Health Services.

C. Birthing Classes. Birthing classes are covered, one course, per pregnancy at a CareFirst BlueChoice approved facility.

1.7 Hemophilia and Congenital Bleeding Disorders. Coverage includes expenses incurred in

connection with:

A. The treatment of routine bleeding episodes associated with hemophilia and congenital bleeding disorders, including prophylactic treatment; and

B. The purchase of blood products and blood infusion equipment (including needles and syringes) required for home treatment of routine bleeding episodes associated with hemophilia and congenital bleeding disorders.

1.8 Lymphedema. Benefits will be provided for equipment, supplies, complex decongestive therapy and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care provider legally authorized to prescribe or provide such items under law.

1.9 Morbid Obesity.

A. Benefits are available for gastric bypass surgery or other such methods recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity. Member eligibility for benefits under this provision shall be based on the current clinical guidelines recognized by the National Institutes of Health.

B. Morbid Obesity is defined as:

1. a weight that is at least one hundred (100) pounds over or twice the ideal weight for frame, age, weight, height, and gender as specified in the 1983 Metropolitan Life Insurance Tables; or

2. a body mass index (BMI) of forty (40) kilograms per meter squared or;

3. a BMI of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes.

C. As used above, BMI equals weight in kilograms divided by height in meters squared.

1.10 Diabetic Supplies and Services.

A. Coverage will be provided for Medically Necessary diabetes equipment, diabetes supplies, and diabetes outpatient self-management training and educational services, including medical nutritional counseling at a CareFirst BlueChoice approved facility.

B. The services must be Medically Necessary as determined by CareFirst BlueChoice for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy. Coverage includes the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.

C. In-person, outpatient self-management training and educational services, including medical nutritional therapy, shall be provided through an in-person program provided by an appropriately licensed, registered, or certified CareFirst BlueChoice approved facility or health care provider whose scope of practice includes diabetes education or management.

1.11 Dental Services.

A. Accidental Injury. Benefits include Medically Necessary, as determined by CareFirst BlueChoice, dental services needed as a result of an accidental bodily injury (except for accidents caused by chewing). For injuries occurring on or after the effective date of coverage under the Evidence of Coverage, treatment must be requested by the Member

within 60 days of the accident.

B. General Anesthesia for Dental Care. Benefits for Medically Necessary general anesthesia in conjunction with dental care and associated Hospital or ambulatory facility charges will be provided to a Member when determined by a licensed dentist in consultation with the Member's treating physician to effectively and safely provide dental care.

1. If the Member is:

a. Five years of age or younger;

b. Severely disabled; or

c. Has a medical condition that requires admission to a Hospital or outpatient surgical facility for general anesthesia for dental treatment.

2. A determination of Medical Necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition requires general anesthesia and the admission to a Hospital or outpatient surgery facility in order to safely provide the dental care.

3. 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 to whom Hospital privileges have been granted.

4. Benefits for the general anesthesia and associated Hospital or ambulatory facility charges require prior authorization by CareFirst BlueChoice. The Member or provider of service must contact CareFirst BlueChoice prior to the date that services are rendered to obtain approval.

5. Benefits for the underlying dental care are not covered.

1.12 Oral Surgery. Benefits include:

A. Medically Necessary procedures, as determined by CareFirst BlueChoice, to attain functional capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or exostoses, or drain abscesses with cellulitis and are performed on lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, and jaws.

B. Medically Necessary procedures, as determined by CareFirst BlueChoice, needed as a result of an accidental injury. For injuries occurring on or after the effective date of coverage under the Evidence of Coverage, the Member must request oral surgical services or dental services for sound natural teeth and supporting structures or the need for oral surgical services or dental services for sound natural teeth and supporting structures must be identified in the Member's medical records within 60 days of the accident.

C. Medically Necessary conservative treatment and surgery, as determined by CareFirst BlueChoice, for temporomandibular joint (TMJ) dysfunction.

D. All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for cosmetic purposes or for correction of

malocclusion unrelated to a functional impairment are excluded.

1.13 Reconstructive Breast Surgery. Benefits will be provided for reconstructive breast surgery resulting from a Mastectomy. Mastectomy means the surgical removal of all or part of a breast.

A. Reconstructive breast surgery includes:

1. Augmentation mammoplasty;

2. Reduction mammoplasty; and

3. Mastopexy.

B. Benefits are provided for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery on the diseased breast is performed.

C. Benefits are provided regardless of whether the Mastectomy was performed while the Member was covered under the Evidence of Coverage.

D. Coverage will be provided for prostheses for a Member who has undergone a Mastectomy as well as services resulting from physical complications at all stages of Mastectomy including lymphedema.

1.14 Reconstructive Surgery. Benefits for reconstructive surgery are limited to surgical procedures that are Medically Necessary, as determined by CareFirst BlueChoice, operative procedures performed on structures of the body to improve/restore bodily function or to correct deformity resulting from disease, trauma, or previous therapeutic intervention.

1.15 Hair Prosthesis. Subject to limitations, if any, stated in the Schedule of Benefits, benefits for a hair prosthesis are provided when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.

SECTION 2
INPATIENT HOSPITAL SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In a Contracting Provider Hospital when admitted under the care of a Primary Care Physician or by another Contracting Physician.	Coverage for the services listed below. The coverage is subject to limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOSPITAL ADMISSIONS MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

2.1 Covered Inpatient Hospital Services. A Member will receive benefits for services listed below when admitted to a Contracting Provider Hospital under the care of a Primary Care Physician or other Contracting Physician. Coverage of inpatient Hospital services is subject to certification by Utilization Management for Medical Necessity. Benefits are provided for:

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

B. Physician and Medical Services. Inpatient physician and medical services provided by or under the direction of the attending Contracting Physician, including:

1. Inpatient Contracting Physician visits.

2. Consultations by Contracting Physician Specialists.

3. Intensive care services.

4. Rehabilitation Services.

5. Respiratory therapy, radiation therapy and chemotherapy services.

6. Anesthesia services and supplies.

7. Diagnostic procedures, laboratory tests and x-ray services.

C. Services and Supplies. Related inpatient services and supplies that are not Experimental/ Investigational, as determined by CareFirst BlueChoice, and ordinarily furnished by the Hospital to its patients, including:

1. The use of:

a. Operating rooms;

b. Treatment rooms; and

c. Special equipment in the Hospital.

2. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

3. Medical and surgical supplies.

4. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administration of infusions are

covered.

5. Surgically implanted Prosthetic devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants and pacemakers. Available benefits under this provision do not include items such as artificial limbs or eyes, hearing aids, or other external prosthetics, which may be provided under other provisions of the Description of Covered Services.

6. Medical social services.

2.2 Number of Hospital Days Covered. Provided the conditions, including the requirements in Section 2.3 below are met and continue to be met, as determined by CareFirst BlueChoice, Hospital benefits for inpatient Hospital services will be provided as follows, subject to the maximum day limit, if any, stated in the Schedule of Benefits:

A. Hospitalization for Rehabilitation. Benefits are provided for an admission or transfer to a CareFirst BlueChoice approved facility for rehabilitation. Benefits provided during any confinement will not exceed the benefit limitation, if any, stated in the Schedule of Benefits. As used in this paragraph, a confinement means a continuous period of hospitalization or two or more admissions separated by 30 days. This limit on hospitalization applies to any portion of an admission that:

1. Is required primarily for Physical Therapy or other rehabilitative care; and

2. Would not be Medically Necessary based solely on the Member's need for inpatient acute care services other than for rehabilitation.

B. Inpatient Coverage Following a Mastectomy. Coverage will be provided for a minimum Hospital stay of not less than:

1. Forty-eight (48) hours following a radical or modified radical Mastectomy; and

2. Twenty-four (24) hours following a partial Mastectomy with lymph node dissection.

C. Hysterectomies. Coverage will be provided for vaginal hysterectomies and abdominal hysterectomies. Coverage includes a minimum stay in the Hospital of:

1. Not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy; and

2. Not less than forty-eight (48) hours for a vaginal hysterectomy.

In consultation with the Contracting Provider, the Member may elect to stay less than the minimum prescribed above when appropriate.

D. Childbirth. Coverage will be provided for a minimum Hospital stay of not less than:

1. Forty-eight (48) hours for both the mother and newborn following a vaginal delivery;

2. Ninety-six (96) hours for both the mother and newborn following a cesarean section.

Prior authorization is not required for the minimum Hospital stays listed above.

If the delivery occurs in the Hospital, the length of stay begins at the time of the delivery. If the delivery occurs outside of the Hospital, the length of stay begins upon admission to

the Hospital. The Member and provider may agree to an early discharge.

E. Other Hospitalization. Hospitalization for Covered Services, other than those described above, will be provided up to the maximum day limit, if any, stated in the Schedule of Benefits subject to the provisions of Section 2.3.

2.3 Inpatient Hospital Pre-Admission Review. When the Member's Medicare coverage is primary to this CareFirst BlueChoice plan, prior authorization for inpatient Hospital services will not be required. Coverage of inpatient Hospital services is subject to the requirements for pre-admission review, concurrent review and discharge planning for all covered hospitalizations. Such review and approval shall determine:

A. The need for hospitalization;

B. The appropriateness of the approved Hospital or facility requested;

C. The approved length of confinement in accordance with CareFirst BlueChoice established criteria; and

D. Additional aspects such as second surgical opinion and/or pre-admission testing requirements.

Failure or refusal to comply with notice requirements and other CareFirst BlueChoice authorization and approval procedures may result in reduction of benefits or exclusion of services from coverage.

SECTION 3
SKILLED NURSING FACILITY SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In a Contracting Provider Skilled Nursing Facility when admitted under the care of a Primary Care Physician or by another Contracting Physician.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

SKILLED NURSING FACILITY SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

3.1 Definitions.

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

Skilled Nursing Care means non-Custodial Care that requires licensure as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for performance.

3.2 Covered Skilled Nursing Facility Services. When the Member meets the conditions for coverage listed in Section 3.3, the services listed below are available to Members in a Skilled Nursing Facility:

A. Room and board in a semiprivate room.

B. Inpatient physician and medical services provided by or under the direction of the attending Contracting Physician.

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

1. Use of special equipment in the facility.

2. Drugs, medications, solutions, biological preparations, and Medical Supplies used while the Member is an inpatient in the facility.

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

A. The Member must be under the care of his or her Primary Care Physician or other Contracting Physician.

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

C. The Member requires Skilled Nursing Care or skilled rehabilitation services that are

required on a daily basis and can only be provided on an inpatient basis.

3.4 Custodial Care Is Not Provided. Benefits will not be provided for any day in a Skilled Nursing Facility that CareFirst BlueChoice determines is primarily for Custodial Care.

A. Custodial Care means care that is:

1. Not directed to the cure of an illness or recovery from an accident; and

2. Mainly for meeting the activities of daily living, e.g. bathing, eating; and

3. Not routinely provided by a trained medical professional; and

4. May be provided by person without professional medical skills or professional medical training.

B. Services may be deemed Custodial Care even if:

1. A Member cannot self-administer the care;

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

3. Ordered by a physician;

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

5. Covered by Medicare.

3.5 Number of Days of Care. Benefits will be provided up to the maximum day limit, if any, stated in the Schedule of Benefits.

SECTION 4
HOME HEALTH SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In a Member's home by a Contracting Provider Home Health Agency when authorized or approved by CareFirst BlueChoice.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOME HEALTH SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

4.1 Definitions

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

A. the institutionalization of the Member in a Hospital or related institution, or Skilled Nursing Facility would otherwise have been required if home health services were not provided; and,

B. the plan of treatment covering the Home Health service is established and approved in writing by the health care practitioner, and determined to be Medically Necessary by CareFirst BlueChoice.

Skilled Nursing Care means non-Custodial Care that requires licensure as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for performance.

4.2 Covered Home Health Services. Services must be provided within the Service Area when requested by a Primary Care Physician or other physician. Benefits are provided for:

A. Continued care and treatment provided by or under the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Services of a home health aide, medical social worker or registered dietician may be provided, but must be performed under the supervision of a licensed professional (RN or LPN) nurse.

B. Drugs and medications directly administered to the patient during a covered home health visit and incidental Medical Supplies directly expended in the course of a covered home health visit. Drugs, medications and Medical Supplies for home use (other than as described above) and purchase or rental of durable medical equipment are not covered under this section. (See Section 8, Medical Devices and Supplies. Benefits for self-administered prescription drugs may be available through a rider purchased by the Group and attached to the Evidence of Coverage.)

C. Home Health Services authorized or approved by CareFirst BlueChoice as Medically Necessary under the utilization management requirements as meeting the conditions for coverage.

4.3 Conditions for Coverage. Benefits are provided when a Member:

A. Is 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.

B. Receives home health visits as a substitute for Hospital care or for care in a Skilled Nursing Facility (i.e., if home health visits were not provided, the Member would have to

be admitted to a Hospital or Skilled Nursing Facility).

C. Requires and continues to require Skilled Nursing Care or rehabilitation services in order to qualify for home health aide services or other types of home health care.

D. Has a need for home health services that is not custodial in nature.

E. Is under the care of a Primary Care Physician or other physician.

4.4 Number of Home Health Visits. Home health visits will be provided up to the maximum visit limit, if any, stated in the Schedule of Benefits.

4.5 Additional Home Health Benefits.

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

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

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

B. Postpartum Home Visits. Home visits following delivery are covered in accordance with the most current standards published by the American College of Obstetricians and Gynecologists.

1. For a mother and newborn child who have a shorter Hospital stay than that provided under Section 2.2.D, Childbirth, benefits will be provided for:

a. one home visit scheduled to occur within 24 hours after Hospital discharge; and

b. an additional home visit if prescribed by the attending provider.

2. For a mother and newborn child who remain in the Hospital for at least the length of time provided under Section 2.2.D, Childbirth, benefits will be provided for a home visit if prescribed by the attending provider.

SECTION 5
HOSPICE CARE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
As an inpatient or outpatient of a Qualified Hospice Care Program.	Coverage for the services listed below. The coverage is subject to the limitations, if any, listed below or stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

HOSPICE CARE SERVICES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

5.1 Covered Hospice Care Services. Services are covered when provided by a Qualified Hospice Care Program. CareFirst BlueChoice will monitor the care for ongoing appropriateness. Benefits are provided for inpatient and outpatient care and include the following:

A. Intermittent nursing care by or under the direction of a registered nurse.

B. Medical social services for the terminally ill patient and his or her Immediate Family. Immediate Family means the patient's spouse and children or, if the terminally ill patient is a child, the parents, brothers and sisters of the child.

C. Nutritional guidance.

D. Non-Custodial home health visits.

E. Medical/surgical supplies.

F. Laboratory tests and x-ray services.

G. Ambulance services, when Medically Necessary as determined by CareFirst BlueChoice.

H. Home visits within the Service Area.

I. Respite care (limited to three periods of 48 hours in the 180-day benefit period).

J. Bereavement services provided to the Immediate Family of the deceased patient when authorized or approved by CareFirst BlueChoice, subject to the following:

1. Bereavement services will be limited to the 90-day period following the patient's death.

2. A maximum of three visits will be provided.

5.2 Conditions for Coverage. Hospice Care Services must meet the following conditions:

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

B. The Member's attending Primary Care Physician or other referring Contracting Physician must submit a written hospice care services plan of treatment to CareFirst BlueChoice.

C. The Member must meet the criteria of the Qualified Hospice Care Program. A Qualified Hospice Care Program means a coordinated, interdisciplinary program of hospice care provided by a Hospital, qualified home health agency, or other health care facility that is state licensed or certified by the State as a hospice program and approved by CareFirst BlueChoice.

D. The Medical Necessity and continued appropriateness of hospice care services must be authorized or approved by CareFirst BlueChoice as meeting the criteria for coverage.

5.3 Hospice Eligibility Period. The period of time that begins on the first date hospice services are rendered and will terminate one hundred eighty (180) days later or upon the death of the terminally ill Member, whichever occurs first. Any extension of the Hospice Eligibility Period must be authorized or approved by CareFirst BlueChoice.

SECTION 6
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In Contracting Physician's offices or in other CareFirst BlueChoice approved facilities upon prior approval or authorization by the Mental Health Management Program; or	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits
In a CareFirst BlueChoice approved Hospital, Qualified Substance Abuse Treatment Facility, or Partial Hospitalization Program when admitted under the care of a Contracting Physician when referred by the Mental Health Management Program.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits

HOSPITALIZATION MUST BE AUTHORIZED OR APPROVED BY THE MENTAL HEALTH AND SUBSTANCE ABUSE MANAGEMENT PROGR

NOTE: Coverage for Biologically Based Disorders is provided at the same benefit level as for any other medical condition. A Biologically Based Disorder as used in this Description of Covered Services means the following: schizophrenia, schizoaffective disorder, attention deficit hyperactivity disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic disorder, autism and drug and alcohol addiction.

6.1 Definitions.

A. The Mental Health and Substance Abuse Management Program refers to utilization management, benefits administration and provider network activities administered by or on behalf of CareFirst BlueChoice to ensure that mental health and substance abuse services are Medically Necessary and provided in a cost-effective manner.

B. Qualified Substance Abuse Treatment Facility means a non-residential facility or distinct part of a facility which is licensed in the jurisdiction(s) in which it operates and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a substance abuse and alcohol treatment facility that operates a program for the treatment and rehabilitation of alcohol and substance abuse.

C. Qualified Partial Hospitalization Program means a Hospital-based or freestanding facility that is licensed in the jurisdiction(s) in which it operates and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a partial hospitalization program where patients receive treatment for mental illness, emotional disorders, drug abuse or alcohol abuse for a period of a minimum of four hours per day, but not in excess of twelve hours per day.

6.2 Outpatient Mental Health and Substance Abuse Services. Outpatient services must be obtained from Contracting Providers upon referral from the Mental Health and Substance Abuse Management Program.

A. Coverage of mental illness, emotional disorders, drug abuse and alcohol abuse is provided. Services include evaluation, diagnosis and treatment of acute and non-acute conditions.

B. Medication management visits in connection with mental illness, emotional disorders, alcohol abuse and drug abuse will be covered in the same manner as medication management visits for physical illnesses and will not be counted as outpatient mental health or substance abuse treatment visits. Members are not required to obtain prior authorization for methadone maintenance treatment.

C. Coverage of substance abuse and related mental health conditions include detoxification and rehabilitative services in a CareFirst BlueChoice designated program.

6.3 Inpatient Mental Health and Substance Abuse Services. Covered services include the following:

A. Services for care and treatment of mental illness or functional nervous disorders which, in the judgment of CareFirst BlueChoice, are subject to significant improvement through inpatient hospitalization treatment. Inpatient care is not covered if, in the judgment of CareFirst BlueChoice, the condition and/or the treatment to be provided do not meet the criteria established by CareFirst BlueChoice for admission to a Hospital. Hospitalization in a specialized facility that is not a CareFirst BlueChoice approved facility is not covered. Treatment of mental illness or functional nervous disorders that is provided in a CareFirst BlueChoice approved facility but which is not subject to significant improvement is not covered.

B. Diagnosis and treatment for the abuse of or addiction to alcohol and drugs, including inpatient detoxification and rehabilitative services in an acute care Hospital or Qualified Substance Abuse Treatment Facility. The Member must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by CareFirst BlueChoice.

SECTION 7
EMERGENCY SERVICES AND URGENT CARE

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
At Contracting Provider Urgent Care facilities and at Hospital emergency rooms and Non-Contracting Urgent Care facilities in or out of the Service Area.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

7.1 Emergency Services and Urgent Care.

A. Benefits are available to a Member for Emergency Services and Urgent Care twenty-four (24) hours per day regardless of whether rendered inside or outside of the Service Area.

If a Member requires care while traveling or temporarily residing outside the Service Area, the Member must follow the emergency procedures established by CareFirst BlueChoice. In the case of travel or temporary residence outside the Service Area, benefits will be paid or provided for expenses incurred for treatment of an illness or injury only if:

1. The need for care could not reasonably have been foreseen before departing the Service Area or sufficiently in advance so as to permit the Member to return to the Service Area for the care before it became urgent;

2. The care was urgently required to alleviate acute pain or prevent further significant deterioration of the Member's condition;

3. The Member could not, without medically harmful results, return to the Service Area to receive treatment;

4. CareFirst BlueChoice determines that the travel was for some purpose other than the receipt of medical treatment; and,

5. CareFirst BlueChoice determines that the services were Medically Necessary.

B. In the case of a Hospital that has an emergency department, benefits include:

1. Appropriate medical screening;

2. Assessment and stabilization services; and

3. Ancillary services routinely available to the emergency department, to determine whether or not an emergency condition exists.

C. A provider is not required to obtain prior authorization or approval from CareFirst BlueChoice in order to obtain reimbursement for Emergency Services.

D. A Hospital, or other provider, or CareFirst BlueChoice, when CareFirst BlueChoice has reimbursed the provider, may attempt to collect payment from a Member for health care services that do not meet the criteria for Emergency Services.

E. Except as provided below, benefits are not provided for routine follow-up treatment within the Service Area provided by Non-Contracting Providers. Follow-up treatment outside of the Service Area is covered if required in connection with covered out-of-area

Emergency Services or Urgent Care and CareFirst BlueChoice determines that the member could not reasonably be expected to return to the Service Area for such care.

7.2 Notice to CareFirst BlueChoice in the Event of an Emergency.

A. If the Member is admitted to a Hospital as a result of an emergency, CareFirst BlueChoice must be notified the earlier of:

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

2. Within 48 hours after first receiving the care.

B. If it was not reasonably possible to give notice, this requirement will be met if notice was given as soon as reasonably possible. The Member must provide information about the emergency and the care received. If the Member does not return to the Service Area and transfer care to a Contracting Physician or Contracting Provider as soon as, in the judgment of CareFirst BlueChoice, the Member was able to do so without medically harmful results, no further benefits will be provided for services received on or after such date.

7.3 Ambulance Services.

A. Benefits are available for Medically Necessary air transportation and ground ambulance services as authorized and approved by CareFirst BlueChoice.

B. If a Member is outside of the United States and requires treatment for Emergency Services, benefits are provided for Medically Necessary air and ground transportation to the nearest facility where appropriate medical care is available.

7.4 Filing a Claim for a Non-Contracting Provider. A Member must submit a completed claim form to CareFirst BlueChoice within 180 days from the time services were first received. A claim form will be provided to the Member upon request. The Member is also responsible for providing information requested by CareFirst BlueChoice including medical records. If it is not reasonably possible to submit the completed claim form within the required time, the claim shall be submitted as soon as reasonably possible and, except in the absence of legal capacity, not later than one (1) year from the date that the submission of the claim was required.

7.5 Follow-up Care after Emergency Surgery. If CareFirst BlueChoice authorizes, directs, refers, or otherwise allows a Member to access a Hospital emergency facility or other Urgent Care facility for a medical condition that meets the criteria for Emergency Services, as defined in the Evidence of Coverage, and requires emergency surgery:

A. Coverage shall be provided for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's Primary Care Physician; and

B. The Member will be responsible for the same Copayment for each follow-up visit as would be required for a visit to a Contracting Physician for specialty care.

SECTION 8
MEDICAL DEVICES AND SUPPLIES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
Medical Devices and Supplies obtained through designated Contracting Providers.	Coverage for the services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits.

MEDICAL DEVICES AND SUPPLIES MUST BE AUTHORIZED OR APPROVED BY CAREFIRST BLUECHOICE

8.1 Definitions.

A. Medical Device, as used in this Description of Covered Services, means Durable Medical Equipment, Medical Supplies, Prosthetic and Orthotic Devices.

B. Durable Medical Equipment means equipment that:

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 can withstand repeated use.

C. Medical Supplies mean 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. Cannot withstand repeated use;

6. Are usually disposable in nature.

Medical Supplies include, but are not limited to, the following items:

a. Disposable syringes necessary to self-administer insulin or other covered injectables;

b. Ostomy and catheter supplies;

c. Dialysis supplies;

d. Diabetes supplies;

e. Oxygen;

f. Dressings required in connection with a covered injury, surgical procedure or condition.

D. Prosthetic means an item or device that is:

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

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

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

4. Removable and attached externally to the body; and

5. Ordered or prescribed by a qualified Contracting Provider.

E. Orthotic Device means an item that:

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

2. Is prescribed by a qualified Contracting Provider;

3. Is an appliance that is applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;

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

5. Includes devices necessary for post-operative healing.

8.2 Covered Benefits. Benefits will be provided for Medical Devices and Supplies when:

A. Obtained from a designated Contracting Provider; and

B. The Member has coverage under the Evidence of Coverage at the time that the Durable Medical Equipment, Prosthetic, Orthotic Device, or Medical Supplies are prescribed and received. The Member must continue to be eligible for coverage for the duration of time for which Durable Medical Equipment is rented.

8.3 Authorization or Approval of Medical Devices and Supplies by CareFirst BlueChoice. Benefits are limited to the least expensive Medically Necessary Durable Medical Equipment, Medical Supplies, Orthotic Device or Prosthetic adequate to meet the patient's medical needs.

Purchase or rental of Medical Devices and Supplies is at the discretion of CareFirst BlueChoice. To qualify for coverage for Medical Devices and Supplies, the Member or the provider must contact CareFirst BlueChoice prior to the purchase or rental of Medical Devices and Supplies to obtain prior authorization of such purchase or rental. CareFirst BlueChoice will determine the Medical Necessity for the covered Medical Devices and Supplies and the appropriateness of the type of appliance, device, equipment or supply requested. CareFirst BlueChoice will then recommend the Contracting Provider from whom the Member is authorized to obtain the Medical Devices and Supplies in order to receive benefits. Failure to contact CareFirst BlueChoice in advance of the purchase or rental and/or failure and refusal to comply with the authorization given by CareFirst BlueChoice will result in exclusion of the Medical Devices and Supplies from coverage.

8.4 Responsibility of CareFirst BlueChoice. CareFirst BlueChoice will not be liable for any claim, injury, demand or judgment based on tort or other grounds (including express or implied warranty of equipment) arising out of or in connection with the rental, sale, use, maintenance or repair of Medical Devices and Supplies.

8.5 Maximum Annual Limit. Members receive benefits for covered Medical Devices and Supplies up to the maximum annual limit, if any, stated in the Schedule of Benefits.

A. When a maximum annual limitation applies, total payments by CareFirst BlueChoice for Medical Devices and Supplies, including covered maintenance, repair, and/or replacement costs, are limited to the maximum annual limit per Member.

B. If, during any benefit period, a Member exceeds his or her maximum annual limit, the Member will be responsible, throughout the remainder of that benefit period, for the full cost of any covered Medical Devices and Supplies, including repair, maintenance and replacement costs.

C. Diabetic supplies, disposable syringes necessary to self-administer insulin and other supplies for the treatment of diabetes are not subject to the maximum annual limit.

8.6 Covered Services.

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

B. Orthotic Devices and 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.

C. Medical Supplies.

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

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

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

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

8.8 Exclusions. Specific exclusions related to Medical Devices and Supplies are listed with the Exclusions and Limitations at the end of this Description of Covered Services.

SECTION 9
GENERAL PROVISIONS

9.1 Continuing Care with Terminated Providers.

A. When a Contracting Provider terminates their agreement with CareFirst BlueChoice, for any reason except for cause, benefits will be provided for continuing care rendered by the terminated provider as described in this section. CareFirst BlueChoice will send a notice to the Member that the Contracting Provider is no longer available.

B. Benefits are only provided when:

1. A Member was in an active course of treatment with the terminated Contracting Provider prior to the date the Member was notified. The Member needs to request from CareFirst BlueChoice, to continue receiving care from the terminated Contracting Provider. Benefits will be provided until the earlier of, the date the treatment ends or for a period of 90 days from the date the Member is notified by CareFirst BlueChoice that the terminated Contracting Provider is no longer available.

2. A Member who has entered her second trimester of pregnancy may continue to receive Covered Services from the terminated Contracting Provider through postpartum care directly related to the delivery.

3. A Member that was terminally ill (as defined by § 1861(dd)(3)(A) of the Social Security Act) at the time the Contracting Provider's agreement terminated may continue to receive Covered Services directly related to the treatment of the terminal illness until the Member dies.

9.2 Medicare. Prior authorization is not required for services covered by Medicare.

9.3 CareFirst BlueChoice Personnel Availability for Prior Authorization.

CareFirst BlueChoice requires prior authorization for certain medical treatment as stated in this Description of Covered Services. Check the specific description of the Covered Services for a notice regarding prior authorization. CareFirst BlueChoice shall have personnel available to provide prior authorization at all times when such prior authorization is required.

SECTION 10
EXCLUSIONS AND LIMITATIONS

10.1 Coverage is Not Provided For:

A. 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 BlueChoice.

B. 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 BlueChoice.

C. The cost of services that:

1. Are furnished without charge; or

2. Are normally furnished without charge to persons without health insurance coverage; or

3. Would have been furnished without charge if the Member was not covered under the Evidence of Coverage or under any health insurance.

D. Services that are not described as covered in the Evidence of Coverage or that do not meet all other conditions and criteria for coverage, as determined by CareFirst BlueChoice. Referral by a Primary Care Physician and/or the provision of services by a Contracting Provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.

E. Except for Emergency Services, Urgent Care and follow-up care after emergency surgery, benefits will not be provided for any service(s) provided to a Member by Non-Contracting Physicians or Non-Contracting Providers, unless written prior authorization is specifically obtained from CareFirst BlueChoice.

F. Routine, palliative or cosmetic foot care (except for conditions determined by CareFirst BlueChoice 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.

G. Except for treatment for Accidental Injury or benefits for Oral Surgery as described above, dental care including extractions; treatment of cavities; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia, except for the treatment of a cleft lip or cleft palate; false teeth; or any other dental services or supplies. These services may be covered under a separate rider purchased by the Group and attached to the Evidence of Coverage.

H. Benefits will not be provided for cosmetic surgery (except as specifically provided for reconstructive breast surgery and reconstructive surgery as listed above) or other services primarily intended to correct, change or improve appearances.

I. Treatment rendered by a health care provider who is a member of the Member's family (parents, spouse, brothers, sisters, children).

J. Any prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage. Medications that can be self-administered or do not medically require administration by

or under the direction of a physician are not covered even though they may be dispensed or administered in a physician office or provider facility. Benefits for prescription drugs may be available through a rider purchased by the Group and attached to the Evidence of Coverage.

K. 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 BlueChoice, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception 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.

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

M. Services to reverse voluntary, surgically induced infertility, such as a reversal of a sterilization.

N. All assisted reproductive technologies, including artificial insemination and intrauterine insemination, in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same unless covered under a rider purchased by the Group and attached to the Evidence of Coverage.

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

P. Treatment for obesity except for the surgical treatment of Morbid Obesity.

Q. 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.

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

S. Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst BlueChoice.

T. Health education classes and self-help programs, other than birthing classes or for the treatment of diabetes.

U. Acupuncture services except when approved or authorized by CareFirst BlueChoice when used for anesthesia.

V. Any service related to recreational activities. This includes, but is not limited to sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst BlueChoice even though they may have therapeutic value or be provided by a health care provider.

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

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

2. From any federal, state, county or municipal facility 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 facility or other government agency and provided at no charge to the Member, 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.

X. Private duty nursing.

Y. Non-medical, health care provider services, including, but not limited to:

1. Telephone consultations, failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the health care practitioner or the healthcare practitioner's staff.

2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Description of Covered Services are available for Covered Services rendered to the Member by a health care provider.

Z. Educational therapies intended to improve academic performance.

AA. Vocational rehabilitation and employment counseling.

BB. Routine eye examinations, frames and lenses or contact lenses. Benefits for routine eye examinations, frames and lenses or contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.

CC. 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).

DD. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

EE. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.

FF. Travel (except for Medically Necessary air transportation and ground ambulance, as determined by CareFirst BlueChoice, and CareFirst BlueChoice approved services listed in the Transplants section of this Description of Covered Services).

GG. Durable Medical Equipment or Supplies associated or used in conjunction with non-covered items or services.

HH. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

10.2 Organ and Tissue Transplants. Benefits will not be provided for the following:

A. Non-human organs and their implantation.

B. Any Hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.

C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst BlueChoice.

D. Services for a Member who is an organ donor when the recipient is not a Member.

E. Benefits will not be provided for donor search services.

F. Any service, supply or device related to a transplant that is not listed as a benefit in this Description of Covered Services.

10.3 Inpatient Hospital Services. Coverage is not provided for the following:

A. Private room, unless Medically Necessary and authorized or approved by CareFirst BlueChoice. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.

B. Non-medical items and convenience items, such as television, phone rentals, guest trays and laundry charges.

C. Except for covered Emergency Services and Childbirth, a Hospital admission or any portion of a Hospital admission that had not been authorized or approved by CareFirst BlueChoice, whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private duty nursing.

10.4 Home Health Services. Coverage is not provided for:

A. Private duty nursing.

B. Custodial Care.

C. Services in the Member's home if it is outside the Service Area.

10.5 Hospice Benefits. Coverage is not provided for:

A. Services, visits, medical equipment or supplies that are not included in the CareFirst BlueChoice-approved plan of treatment.

B. Services in the Member's home if it is outside the Service Area.

C. Financial and legal counseling.

D. Any service for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.

E. Chemotherapy or radiation therapy, unless used for symptom control.

F. Services, visits, medical/surgical equipment or supplies; including equipment and medication not required to maintain the comfort and to manage the pain of the terminally ill Member.

G. Reimbursement for volunteer services.

H. Custodial Care, domestic or housekeeping services.

I Meals on Wheels or similar food service arrangements.

J. Rental or purchase of renal dialysis equipment and supplies.

K. Private duty nursing.

10.6 Outpatient Mental Health and Substance Abuse. Coverage is not provided for:

A. Psychological testing, unless Medically Necessary, as determined by CareFirst BlueChoice, and appropriate within the scope of Covered Services.

B. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.

C. Mental retardation, after diagnosis.

D. Psychoanalysis.

10.7 Inpatient Mental Health and Substance. The following services are excluded:

A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst BlueChoice Medical Director.

B. Custodial Care.

C. Observation or isolation.

10.8 Emergency Services and Urgent Care. Benefits will not be provided for:

A. Emergency care if the Member could have foreseen the need for the care before it became urgent (for example, periodic chemotherapy or dialysis treatment).

B. Medical services rendered outside of the Service Area which could have been foreseen by the Member prior to departing the Service Area.

C. Charges for emergency and Urgent Care services received from a Non-Contracting Provider after the Member could reasonably be expected to travel to the nearest Contracting Provider.

D. Charges for services when the claims filing and notice procedures stated in Section 7 of this Description of Covered Services have not been followed by the Member.

E. Except for Medically Necessary follow-up care after emergency surgery, charges for follow-up care received in the emergency or Urgent Care facility outside of the Service Area unless CareFirst BlueChoice determines that the Member could not reasonably be expected to return to the Service Area for such care.

F. Except for covered ambulance services, travel, including travel required to return to the Service Area, whether or not recommended by a Contracting Provider.

G. Treatment received in an emergency department to treat a health care problem that does not meet the definition of Emergency Services as defined in Section 7 of this Description of Covered Services.

10.9 Medical Devices and Supplies. Coverage is not provided for:

A. Convenience item. Any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoyer/stair lifts, ramps, shower/bath bench.

B. Furniture items. Movable articles or accessories which serve as a place upon which to rest (people or things) or in which things are placed or stored, e.g. chair or dresser.

C. Exercise equipment. Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen or condition all or part of the human body, e.g. exercycle or other physical fitness equipment.

D. Institutional equipment. Any device or appliance that is appropriate for use in a medical facility and is not appropriate for use in the home, e.g. parallel bars.

E. Environmental control equipment. Any device such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

F. Eyeglasses, contact lenses, dental prostheses or appliances, or hearing aids. Benefits for eyeglasses and contact lenses may be available through a rider purchased by the Group and attached to the Evidence of Coverage.

G. Corrective shoes, unless they are an integral part of the lower body brace, shoe lifts or special shoe accessories.

H. Medical equipment/supplies of an expendable nature, except those specifically listed as a Covered Medical Supply in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

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ATTACHMENT C
SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions set forth in the evidence of coverage.

CareFirst BlueChoice 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 BlueChoice considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures. Certain Utilization Management Requirements may apply. When these rules are not met, payments may be denied or reduced.

Definitions. In addition to the definitions contained in the evidence of coverage, the terms below when capitalized have the following meanings:

Allowed Benefit:

1. For a Plan Physician or Plan Provider, the Allowed Benefit for a covered service is the lesser of:
   a. the actual charge; or
   b. the amount CareFirst BlueChoice allows for the service in effect on the date that the service is rendered.

   The benefit payment is made directly to the Plan Physician or Plan Provider and is accepted as payment in full, except any applicable Deductible, Copayment or Coinsurance as set forth in this Schedule. The Member is responsible for any applicable Deductible, Copayment and Coinsurance and the Plan Physician or Plan Provider may bill the Member directly for such amounts.

2. For a non-Plan Physician or a non-Plan Provider, the Allowed Benefit for a covered service will be determined in the same manner as the Allowed Benefit to a Plan Physician or Plan Provider. Benefits may be paid to the Subscriber or to the non-Plan Physician or non-Plan Provider.

Benefit Period: The period of time during which Covered Services are eligible for payment.

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

Copayment: The dollar amount that a member must pay for certain Covered Services.

Deductible: The dollar amount of the Allowed Benefits payable during a Benefit Period for Covered Services, which must first be incurred by the Member before CareFirst BlueChoice will make payments for Covered Services under this evidence of coverage.

Out-of-Pocket Maximum:	The Out-of-Pocket Maximum limit the maximum amounts that the Member will have to pay for his/her share of benefits in any Benefit Period. Once the Member meets the Out-of-Pocket Maximum, the Member will no longer be required to pay copayments or his/her share of the Coinsurance for the remainder of that Benefit Period.
Lifetime Maximum:	The maximum dollar amount payable toward a Member's claims for Covered Services.

Benefit Period:	Benefit Period is a Contract year.
Deductible:	The Individual Benefit Period Deductible is $1,500. The Two Party or Family Benefit Period Deductible is $3,000. **Individual Coverage:** A Member who has Individual Coverage must satisfy the Individual Deductible. **Two-Party (Individual and Adult, or Individual and Child) Coverage:** Members who have Two-Party Coverage must combine the eligible expenses of all covered Members to satisfy the Two-Party Deductible. **There is no Individual Deductible with Two-Party Coverage.** The Two-Party Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has Two-Party Coverage. . **Individual and Child(ren) or Family Coverage**: Members who have Individual and Child(ren) or Family Coverage must combine the eligible expenses of all covered Members to satisfy the Individual and Child(ren) or Family Deductible**. There is no Individual Deductible with Individual and Child(ren) or Family Coverage.** The Individual and Child(ren) or Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has Individual and Child(ren) or Family Coverage. The benefit chart below states whether a Covered Service is subject to the Benefit Period Deductible. The following amounts apply to the Deductible: • Copayments. • Coinsurance. The following amounts may <u>not</u> be used to satisfy the Benefit Period Deductible: • Amounts incurred for failure to comply with the Utilization Management Program requirements. • The portion of any provider charge that is in excess of the Allowed Benefit. • Charges for services which are not covered under the evidence of coverage or which exceed the maximum number of covered visits/days listed below. • Copayments or Coinsurance, if any, required under any riders or amendments to the evidence of coverage unless the rider or amendment specifically states otherwise.
Deductible Credit	If a Member was covered on the day immediately preceding the effective date of this contract under any other group agreement issued to the Group, then charges for Covered Services (as defined) incurred by that Member and applicable toward the Individual or Family Deductible under the prior agreement, shall be used to satisfy all or any portion of the Individual or Family aggregate Deductible amounts under this contract. This Deductible Credit provision applies only to the Deductible amount wholly or partially satisfied in the same Benefit Period as the effective date of this contract. Deductible credit only applies to initial enrollees. Deductible credit is not provided for Prescription Drugs.

Out-of-Pocket Maximum:	The individual Benefit Period Out-of-Pocket Maximum is $3,000. The Two Party or Family Benefit Period Out-of-Pocket Maximum is $6,550. **Individual Coverage:** A Member who has Self-Only Coverage must meet the Individual Out-of-Pocket Maximum. **Two-Party (Individual and Adult, or Individual and Child) Coverage:** Members who have Two-Party Coverage must combine the eligible expenses of all covered Members to satisfy the Two-Party Out-of-Pocket Maximum. **There is no Individual Out-of-Pocket Maximum with Two-Party Coverage.** The Two-Party Out-of-Pocket Maximum must be reached before CareFirst waives payment of the above listed amounts applying to the Out-of-Pocket Maximum. **Individual and Child(ren) or Family Coverage:** Members who have Individual and Child(ren) or Family Coverage must combine the eligible expenses of all covered Members to satisfy the Individual and Child(ren) or Family Out-of-Pocket Maximum**. There is no Individual Out-of-Pocket Maximum with Individual and Child(ren) or Family Coverage.** The Individual and Child(ren) or Family Out-of-Pocket Maximum must be reached before CareFirst waives payment of the above listed amounts applying to the Out-of-Pocket Maximum. These amounts apply to the Benefit Period Out-of-Pocket Maximum: • Coinsurance for all Covered Services, including Coinsurance under the Prescription Drug Benefits Rider. • Copayments for all Covered Services, including Copayments under the Prescription Drug Benefits Rider. • The Benefit Period Deductible. When the Member has reached the Benefit Period Out-of-Pocket Maximum no further Copayments, Coinsurance or Deductibles will be required in that Benefit Period for Covered Services. The following amounts may <u>not</u> be used to satisfy the Benefit Period Out-of-Pocket Maximum: • Amounts incurred for failure to comply with the Utilization Management Program requirements. • The portion of any provider charge that is in excess of the Allowed Benefit. • Charges for services which are not covered under the evidence of coverage or which exceed the maximum number of covered visits/days listed below. • Copayments or Coinsurance, if any, required under any riders or amendments to the evidence of coverage unless the rider or amendment specifically states otherwise.
Lifetime Maximum:	There is no Lifetime Maximum.

SERVICE	LIMIT ON BENEFITS	SUBJECT TO DEDUCTIBLE	MEMBER PAYMENT
SECTION 1 - MEDICAL SERVICES			
Office Visits		Yes	$10 per visit (PCP) $20 per visit (Specialist)
Laboratory Tests and X-rays		Yes	No Copayment or Coinsurance.
Other Diagnostic Testing (except as otherwise provided)		Yes	$10 per visit (PCP) $20 per visit (Specialist)
Limited Service Immediate Care		Yes	$20 per visit
Preventive Services			
Well Child Care		No	No Copayment or Coinsurance.
Adult Preventive Care		No	No Copayment or Coinsurance.
Cancer Screening Tests			
Prostate Cancer Screening	Age 40 and above who are at high risk and age 50 and above: One PSA test in a 12-month period and digital rectal exams. In accordance with the most current American Cancer Society guidelines.	No	No Copayment or Coinsurance.
Colorectal Cancer Screening	In accordance with the most current American College of Gastroenterology guidelines, in consultation with the American Cancer Society.	No	No Copayment or Coinsurance.
Pap Smear	One annual pap smear and FDA approved Gynecologic Cytology screening.	No	No Copayment or Coinsurance.
Mammography	Age 35-39: One baseline mammogram of each breast Age 40-49: One mammogram of each breast every two (2) years Age 50 and above: One annual mammogram of each breast.	No	No Copayment or Coinsurance.
Eye Care Services			
Medical Treatment		Yes	$10 per visit (PCP) $20 per visit (Specialist)
Diagnostic and Treatment			
Allergy Treatment	Number of visits not limited	Yes	$10 per visit (PCP) $20 per visit (Specialist)

SERVICE	LIMIT ON BENEFITS	SUBJECT TO DEDUCTIBLE	MEMBER PAYMENT
Rehabilitation Services (includes Physical Therapy, Occupational Therapy and Speech Therapy)	No referral or prior authorization required. Limited to 30 visits per condition per Benefit Period.	Yes	$20 per visit
Spinal Manipulation Services	No referral or prior authorization required. Limited to 20 visits per Benefit Period.	Yes	$20 per visit
Early Intervention Services	No referral or prior authorization required. Limited to $5,000 per Member per Benefit Period. Limited to Members from birth through age 3. Benefits received will not apply to the Lifetime Maximum.	Yes	$20 per visit
Chemotherapy		Yes	$20 per visit
Maternity and Related Services			
Maternity Care		Yes	$10 per visit (PCP) $20 per visit (Specialist)
Hair Prosthesis			
Hair Prosthesis	Limited to a maximum CareFirst BlueChoice payment of $350 for one hair prosthesis per Benefit Period.	Yes	No Copayment or Coinsurance.
Outpatient Services			
Outpatient hospital or ambulatory care facility		Yes	No Copayment or Coinsurance.
Outpatient medical and surgical professional services provided at an outpatient hospital or ambulatory care facility		Yes	$10 per visit (PCP) $20 per visit (Specialist)
Cardiac Rehabilitation	Limited to 90 visits per Benefit Period.	Yes	$20 per visit

SERVICE	LIMIT ON BENEFITS	SUBJECT TO DEDUCTIBLE	MEMBER PAYMENT
SECTION 2 - INPATIENT HOSPITAL SERVICES			
Inpatient Facility (medical or surgical condition, including maternity)	No prior authorization for routine maternity admissions required.	Yes	$250 Copayment per admission, after the Deductible.
Inpatient Facility (Rehabilitation Services)	Limited to 90 days per Benefit Period.	Yes	$250 Copayment per admission, after the Deductible.
Professional Services		Yes	No Copayment or Coinsurance.
SECTION 3 -- SKILLED NURSING FACILITY SERVICES			
		Yes	No Copayment or Coinsurance.
SECTION 4 - HOME HEALTH CARE SERVICES			
	Number of visits not limited	Yes	No Copayment or Coinsurance.
SECTION 5 - HOSPICE CARE SERVICES			
Limited to the Hospice Eligibility Period. See Section 5.3 of Attachment B, Description of Covered Services.			
Hospice Care	Unlimited visits during Hospice Eligibility Period	Yes	No Copayment or Coinsurance.
Respite Care	Limited to 3 periods of 48 hours in the Hospice Eligibility Period	Yes	No Copayment or Coinsurance.
Bereavement Services	Limited to the 90-day period following the Member's death and a maximum of 3 visits	Yes	No Copayment or Coinsurance.
SECTION 6 - MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Benefits will be provided at the same level as benefits for Section 1 (Medical Services) Section 2 (Inpatient Hospital Services) and Section 7 (Emergency Services and Urgent Care) for covered services rendered in connection with the following diagnoses: schizophrenia, schizoaffective disorder, attention deficit hyperactivity disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, autism, panic disorder, and drug and alcohol addiction. For all other diagnoses refer to the applicable coverage provisions below.			
Outpatient Services		Yes	$10 per visit
Medication Management	Not counted towards the outpatient visit limit.	Yes	$10 per visit (PCP) $20 per visit (Specialist)
Inpatient Services			
Facility Services		Yes	$250 Copayment per admission, after the Deductible.
Professional Services		Yes	No Copayment or Coinsurance.
Partial Hospitalization Program	Every 2 days are counted as one day toward the inpatient limit.	Yes	No Copayment or Coinsurance.
SECTION 7 - EMERGENCY SERVICES AND URGENT CARE			
Plan Provider Urgent Care Facility	Limited to Emergency Services or unexpected, urgently required services.	Yes	$20 per visit

SERVICE	LIMIT ON BENEFITS	SUBJECT TO DEDUCTIBLE	MEMBER PAYMENT
Hospital Emergency Room or Non-Plan Urgent Care Facility	Limited to Emergency Services or unexpected, urgently required services.	Yes	$100 per visit, waived if admitted as inpatient
Other Emergency Services or urgently required services provided by a non-Plan Physician	Limited to unexpected, urgently required services	Yes	$20 per visit
SECTION 8 - MEDICAL DEVICES			
Medical Devices or Supplies	Limited to a maximum CareFirst BlueChoice payment of $7500 per Benefit Period.	Yes	25% of Allowed Benefit after the Deductible has been met

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COVERAGE OF PROSTHETIC DEVICES AMENDMENT

This amendment is effective on January 1, 2010.

I. The Evidence of Coverage, Description of Covered Services, Medical Devices and Supplies Section is amended to add the following:

Prosthetic Leg, Arm, Hand or Foot

1. Coverage shall be provided for an artificial device which replaces, in whole or in part, a leg, arm, hand, or foot.

2. Coverage includes:
   a. Components of prosthetic devices; and

   b. Repairs, fitting, and replacement of prosthetic devices.

3. Benefits for prosthetic legs, arms, hands, or feet do not accrue to any applicable annual dollar maximum for medical devices and supplies.

4. Requirements for Medical Necessity for coverage of a prosthetic leg, arm, hand, or foot will not be more restrictive than the limitations of coverage provided any other benefit under this Evidence of Coverage.

5. Prior authorization is required for benefits for prosthetic legs, arms, hands, or feet.

Prosthetic device coverage does not include repair and replacement due to a Member's neglect, misuse, or abuse. Coverage also does not include prosthetic devices designed primarily for an athletic purpose.

Benefits for charges related to coverage of prosthetic leg, arm, hand, or foot are provided as stated in the Medical Devices Section of the Schedule of Benefits.

The annual dollar maximum stated in the Medical Devices Section of the Schedule of Benefits does not apply to prosthetic legs, arms, hands, or feet.

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 in this amendment.

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SPECIAL ENROLLMENT 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 Section 2.6, Enrollment Opportunities and Effective Dates, of the Evidence of Coverage as section 2.6.E:

2.6.E. Special Enrollment Regarding Medicaid and CHIP Termination or Eligibility: CareFirst BlueChoice 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 assistance, with respect to coverage under the group health plan or health insurance 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).

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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.

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The Evidence of Coverage is amended as follows:

A. Definitions

The definition of Emergency Services, in Section 1 of the Evidence of Coverage, is deleted and replaced with the following:

Emergency Services means:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

The following definitions are added to Section 1 of the Evidence of Coverage.

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

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

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

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.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with CareFirst BlueChoice to provide health care services to Members.

B. Annual Dollar Limits

The annual dollar limit stated in Section 1.1. N.3.a. of the Description of Covered Services, for Early Intervention Services is deleted.

The Schedule of Benefits is amended to delete any annual dollar limit on Essential Health Benefits that is stated in the "Limit on Benefits" column except as provided in this amendment. The annual dollar limitation on hair prostheses shall not be affected by this amendment.

C. Rescission

Section XI of the Group Contract, is amended to add the following:

CareFirst BlueChoice may rescind or void the coverage of a Member only if (1) the Member performs an act, practice, or omission that constitutes fraud; or (2) the Member makes an intentional misrepresentation of material fact in the application.

CareFirst BlueChoice will provide 31-days advance written notice of any rescission of coverage and refund any paid premiums to the group.

Nothing in this amendment shall be construed to limit or abrogate any right or remedy available to CareFirst BlueChoice under Section XI of the Group Contract that does not relate to a rescission of coverage.

D. Preventive Services

Section 1.1.D, in the Description of Covered Services, is amended to add the following:

D. Preventive Services.
In addition to the benefits listed in this provision, 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 the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended, as well as CareFirst preventive guidelines.

CareFirst shall cover the following preventive services and shall not impose any cost-sharing requirements, such as deductibles or Copayment or Coinsurance amounts to any Member receiving any of the following benefits for services received from participating providers. CareFirst shall update new recommendations to the preventive benefits listed in the provision at the schedule established by the Secretary of Health and Human Services.

1. Cancer Screening. Benefits are provided for cancer screening, including:

a. Prostate cancer examinations. Benefits are available when rendered in accordance with the most current American Cancer Society's guidelines and include a medically recognized diagnostic examination, digital rectal exams and the prostate-specific antigen (PSA) tests.

b. Colorectal cancer screening. Benefits are available for a medically recognized diagnostic examination in accordance with the most recently published recommendations of the American College of Gastroenterology, in consultation with the most current American Cancer

Society guidelines appropriate for age, family history and frequency and shall include:

i. Annual fecal occult blood test;

ii. Flexible sigmoidoscopy;

iii. Colonoscopy; and,

iv. Radiologic imaging.

c. A minimum of one annual pap smear, including tests performed using FDA approved gynecological cytology screening technologies. Additional Medically Necessary pap smear tests, as determined appropriate by CareFirst BlueChoice.

d. Low dose mammography screenings to determine the presence of occult breast cancer as determined to be appropriate by a Contracting Physician.

Benefits will also be provided in accordance with the current recommendations of the United States Preventive Service Task Force (except those issued in or around 2009) regarding breast cancer screening, mammography, and prevention.

2. Immunizations. Coverage is provided in accordance with accepted medical practice and there is in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. Immunizations required solely for travel are not covered.

3. Well child preventive care and pediatric services in accordance with the most recent guidelines of the American Academy of Pediatrics. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Benefits are also available for oral and vision care, as described elsewhere in the Evidence of Coverage.

4. Adult preventive and routine gynecological care. Benefits include health care services incidental to and rendered during an annual visit, including evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

CareFirst BlueChoice shall update new recommendations to the preventive services listed above pursuant to the schedule established by the Secretary of the United States Department of Health and Human Services.

E. Emergency Services

Section 7 of the Description of Covered Services is amended to add:

Emergency Services by Non-Participating Providers. Benefits are provided:

A. Without the need for any prior authorization determination, even if the Emergency Services are provided by a Non-Participating Provider;

B. Without regard to whether the health care provider furnishing the Emergency Services is a participating provider with respect to the services; and

C. If the Emergency Services are provided by a Non-Participating Provider, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from participating providers.

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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TELEMEDICINE SERVICES AMENDMENT

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

I. The Evidence of Coverage, Description of Covered Services is amended to add the following:

Telemedicine Services

1. Coverage shall be provided for the use of interactive audio, video, or other electronic media for the purpose of consultation, diagnosis, or treatment of the patient.

2. Benefits for telemedicine services shall be provided by a health care provider to deliver health care services within the scope of the provider's practice at a site other than the site where the patient is located.

3. Benefits for telemedicine services are not subject to any annual dollar maximum or annual visit limitation.

4. CareFirst BlueChoice shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

5. Prior authorization is not required for emergent telemedicine services.

Telemedicine services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a health care provider and a patient.

Benefits for charges related to coverage of telemedicine services, as stated above, are provided to the same extent as benefits provided for similar treatment of preventive services or other illnesses.

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 in this amendment.

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CONTINUATION OF COVERAGE AND CONVERSION PRIVILEGE AMENDMENT

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

SECTION 4, CONTINUATION OF COVERAGE, provisions 4.2 and 4.3 are deleted and replaced with the following:

4.2 Additional Right to Continue Group Coverage. A Member has the right to have the present coverage under the Group policy continued for a period of twelve (12) months immediately following the date of the termination of the Member's eligibility, without evidence of insurability, subject to the following requirements:

A. The Member was covered under the Group Contract for at least three (3) months prior to termination;

B. The Member is not:

1. Covered by or eligible for benefits under Medicare;

2. Covered by or eligible for substantially the same level of Hospital, medical, and surgical benefits under state or federal law;

3. Covered by substantially the same level of benefits under any policy, contract, or plan for individuals in a group;

C. The Member was not terminated from this Evidence of Coverage for:

1. Failure to pay the premium;

2. Fraud or material misrepresentation, in enrollment or in the use of services or facilities; or,

3. Violation of the terms of the prior contract.

D. The application for the extended coverage is made to the Group policyholder within thirty-one (31) days after written notice of this continuation right but under no circumstances after sixty (60) days following the date of termination and the premium for the twelve (12) month continuation period is paid to the Group on a monthly basis during the twelve (12) month period.

E. The premium for continuing the Group coverage shall be at the insurer's current rate applicable to the Group policy, plus any applicable administrative fee not to exceed two (2) percent of the current rate.

The above provision shall not apply if the Group is required to provide for continuation of coverage under its Group policy pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

4.3 Right to Continue Coverage Under Only One Provision. If a Member is eligible to continue coverage under the Group Contract under more than one continuation provision as described in Sections 4.2 and 5.1, the Member will receive only one such continuation coverage. The Group will select the continuation option the member will receive.

SECTION 5, CONVERSION PRIVILEGE, provisions 5.1 A and 5.2 A are deleted and replaced with the following:

5.1 A. Group Conversion. All Members covered under this Evidence of Coverage whose coverage is terminated for any reason except those listed in Section 5.1.B below are eligible to apply for a Conversion Contract. The Member must apply within thirty-one (31) days after written notification but no later than sixty (60) days following the date of termination. Conversion coverage will not be denied because the Member does not reside or work in the Service Area.

5.2 A. CareFirst BlueChoice must receive a completed application from the Member, including full payment of the first premium, within thirty-one (31) days after written notification but no later than sixty (60) days following the date of termination.

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 in this amendment.

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MAMMOGRAPHY AMENDMENT

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

The Limit on Benefits for Mammography in Section 1 of the Schedule of Benefits is deleted.

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 BlueChoice, Inc.

Chester E. Burrell
President and Chief Executive Officer

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An independent licensee of the Blue Cross and Blue Shield Association

OBESITY PREVENTION AND TREATMENT AMENDMENT

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

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

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

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

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

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

D. Office visits for the treatment of childhood obesity.

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

F. Benefits for Prevention and Treatment of Obesity are available to the same extent as office visit benefits provided for preventive care services.

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

Professional Nutritional Counseling and Medical Nutritional Therapy.

A. Definitions

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

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

B. Covered Services. Benefits are available for Medically Necessary Professional Nutritional Counseling and Medical Nutrition Therapy as determined by CareFirst BlueChoice.

C. Benefits for Professional Nutritional Counseling and Medical Nutrition Therapy are available to the same extent as benefits provided for PCP office visits for medical treatment.

III. Description of Covered Services, Section 10, Exclusions and Limitations, Section 10.1, item P, is deleted and replaced with the following:

P. Medical or surgical treatment for obesity, including medical or surgical treatment for morbid obesity, weight reduction, dietary control or commercial weight loss programs. This exclusion does not apply to:

1. Surgical procedures for the treatment of Morbid Obesity;

2. Well child care visits for obesity evaluation and management;

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

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

5. Office visits for the treatment of childhood obesity; and

6. Professional Nutritional Counseling and Medical Nutrition Therapy as described in this amendment.

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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EXPANSION OF DEPENDENT COVERAGE AMENDMENT

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

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The Evidence of Coverage is amended as follows:

A. DEFINITION OF DEPENDENT CHILD

For the purposes of this amendment, a Dependent child is a child who is:

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

2. A child placed with the Subscriber or the Subscriber's covered Spouse for legal Adoption; or

3. A child under testamentary or court appointed guardianship, other than temporary guardianship for less than 12 months' duration, of the Subscriber or the Subscriber's covered Spouse;

All provisions of the Evidence of Coverage that define or describe the eligibility of a Dependent child who is described above for coverage under the Evidence of Coverage are revised to include a Dependent child described above 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; or
6. Satisfaction of any combination of the above factors.

Nothing in this amendment changes or amends the eligibility requirements for grandchildren that are stated in the Evidence of Coverage or in the Eligibility Schedule attached to the Evidence of Coverage.

B. ELIGIBILITY OF DEPENDENT CHILDREN

All provisions of the Evidence of Coverage that state that the eligibility for coverage of a Dependent child described in Section A above 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 described in Section A above, prior to his or her 26th 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 or to alter any requirement related to the eligibility of a dependent grandchild.

The eligibility requirements for grandchildren remain as stated in the Evidence of Coverage and in the Eligibility Schedule attached to the Evidence of Coverage.

C. TERMINATION OF DEPENDENT CHILDREN

All provisions of the Evidence of Coverage that state that the coverage of a Dependent child described in Section A above 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 described in Section A above 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 described in Section A above, 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 described in Section A above 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.

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 in this amendment.

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PATIENT-CENTERED MEDICAL HOME PROGRAM 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. Evidence of Coverage 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.

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

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

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

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

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

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

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

C. Except for an Evidence of Coverage used in conjunction with a Health Savings Account (HSA), Patient-Centered Medical Home Program benefits are not subject to the Deductible. There is no Copayment or Coinsurance for benefits provided under this amendment.

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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INPATIENT MATERNITY PRIOR AUTHORIZATION AMENDMENT

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

1. The following statement is added to Section 2.3 of the Description of Covered Services:

   No prior authorization is required for inpatient maternity admissions.

2. Schedule of Benefits- Inpatient Hospital Services section, the text in the "Limit on Benefits" column that states "No prior authorization for routine maternity admission required" is deleted and replaced with the following:

   No prior authorization is required for inpatient maternity admissions.

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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WOMEN'S PREVENTIVE HEALTH SERVICES AMENDMENT

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

I. Section 1.1.L of the Description of Covered Services is deleted and replaced with the following:

L. Family Planning Services.

1. Covered Benefits.

a) Contraceptive counseling. Patient education and counseling for all female Members with reproductive capacity.

b) Coverage will be provided for the insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs that is approved by the FDA, for use by women, as a contraceptive.

c) Benefits will also be provided for contraceptive devices or drugs that are approved by the FDA, for use by women, as a contraceptive that must be administered to the Member in the course of a covered outpatient or inpatient treatment.

d) Elective sterilization services. See the Schedule of Benefits for benefit limitations, if any.

2. Limitations

Contraceptive devices and drugs that do not require administration by or under the direction of a physician or drugs and devices that can be self-administered by the patient or an average individual who does not have medical training are not covered under the Description of Covered Services. Benefits for contraceptive devices and drugs that do not require administration by or under the direction of a physician or drugs and devices that can be self-administered by the patient or an average individual who does not have medical training may be covered under the Prescription Drug Benefits Rider purchased by the Group and attached to this Evidence of Coverage.

II. The Description of Covered Services, Section 1.1D, is amended to add the following:

1.1D.5 Preventive services covered under this Evidence of Coverage include: screening for gestational diabetes; human papillomavirus testing; counseling for sexually transmitted infections; counseling and screening for human immune deficiency virus; breastfeeding support supplies and counseling, and; screening and counseling for interpersonal and domestic violence. These services, except for breastfeeding equipment, are covered to the same extent as other preventive services in the Schedule of Benefits. Breastfeeding equipment is covered as stated in the Schedule of Benefits.

III. The Description of Covered Services, Section 1.7, is deleted and replaced with the following:

1.7 Maternity Benefits.

A. Maternity Services. Benefits are provided for all female Members including:

1. Preventive Services

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

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

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

d) Breastfeeding support, supplies and consultation.

e) These services, except for breastfeeding equipment, are covered without any Deductible, Copayment or Coinsurance. Breastfeeding equipment is covered as stated in the Schedule of Benefits.

2. Outpatient obstetrical care and professional services for all prenatal and post-partum complications, including prenatal and post-partum office visits and Ancillary Services provided during those visits.

3. Other non-preventive prenatal laboratory tests and diagnostics services are covered to the same extent as other laboratory testing and diagnostic services.

4. Coverage for a hospital stay.

5. Coverage for care rendered by a CareFirst BlueChoice approved licensed birthing center.

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

7. Newborn hearing screening prior to discharge.

B. Postpartum Home Visits. See Section 4.5B, Home Health Services.

C. Birthing Classes. Birthing classes are covered, one course per pregnancy at a CareFirst BlueChoice approved facility.

IV. Schedule of Benefits- Outpatient and Office Services, Maternity Care section, the following text is added to the "Limit on Benefits" column:

Preventive prenatal services as stated in the Description of Covered Services, other than breastfeeding equipment, are covered without any Deductible, Copayment or Coinsurance. Breastfeeding equipment is covered as separately stated in this Schedule of Benefits.

V. The Schedule of Benefits is amended to add the following:

Service	Limit on Benefits	Member Payment
Contraceptive Methods and Counseling for Women	Benefits available to female Members with reproductive capacity, only.	No Copayment or Coinsurance
Breastfeeding Equipment	In conjunction with each birth	No Copayment or Coinsurance

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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2014 CONTROLLED CLINICAL TRIALS MANDATE 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:

Section 1.5 of the Description of Covered Services is deleted and replaced with the following:

1.5 Controlled Clinical Trials.

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, National Cancer Institute Community Clinical Oncology Program, AIDS Clinical Trials Group, and 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.

Qualified Individual, as used in this section, means a Member who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to the treatment of cancer or other life-threatening disease or condition, and the provider who recommended the Member for the clinical trial has concluded that the Member's participation in such trial is appropriate to treat the disease or condition, or the Member's participation is based on medical and scientific information.

Routine Patient Costs means the costs of all Medically Necessary items and health care services consistent with the Covered Services that are typically provided for a Qualified Individual who is not enrolled in a clinical trial that are incurred as a result of the treatment being provided to the Qualified Individual for purposes of the clinical trial. Routine Patient Costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

B. Covered Services

1. Benefits for Routine Patient Costs to a Qualified Individual in a clinical trial will be provided if the Qualified Individual's participation in the clinical trial is the result of:

a) Treatment provided for a life-threatening disease or condition; or

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

2. Coverage for Routine Patient Costs 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;

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

   c) The treatment is being provided in a federally funded or approved clinical trial including, but not limited to, a clinical trial approved by one of the National Institutes of Health, an NIH Cooperative Group, an NIH Center, the FDA in the form of an investigational new drug application, 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 treatment is being provided under an investigational new drug application reviewed by the FDA; or

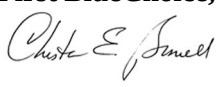
   e) The treatment is being provided under a drug trial that is exempt from the requirement of an investigational new drug application; and

   f) Prior authorization has been obtained from CareFirst BlueChoice.

3. Coverage is provided for the Routine Patient Costs 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 Qualified Individual'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.

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 BlueChoice, Inc.



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CONVERSION PRIVILEGE TERMINATION AMENDMENT

This amendment is effective _____. If no date is shown, this amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

The following shall supersede and replace any provisions to the contrary.

The Evidence of Coverage is amended as follows:
There are no conversion privileges under this Evidence of Coverage. All references to conversion privileges within this Evidence of Coverage are hereby deleted as noted below.

Conversion Privilege Termination

1. Within Section 1, Definitions, of the Evidence of Coverage, the definition of "Conversion Contract" is deleted.

2. Section 3.4, Conversion Privilege, of the Termination of Coverage section of the Evidence of Coverage is deleted.

3. Section 5, Conversion Privilege, of the Evidence of Coverage, and the reference to this section in the Table of Contents are deleted.

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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2015 AMENDMENT

This amendment is effective _____. If no date is shown, this amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

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The Evidence of Coverage is amended as follows:

SECTION A – COORDINATION OF BENEFITS

Section 5.2 of the Evidence of Coverage is deleted and replaced with the following:

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

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

B. Medicare as Primary.

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

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

SECTION B – DEFINED TERM

The definition of "Spouse" is deleted and replaced with the following:

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

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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AUTISM SPECTRUM DISORDER AMENDMENT

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

I. The Evidence of Coverage, Section I, Definitions is amended to add the following:

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

Autism Spectrum Disorder means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's Syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder - Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Behavioral Health Treatment means professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

Diagnosis of Autism Spectrum Disorder means Medically Necessary assessments, evaluations, or tests to diagnose whether an individual has an Autism Spectrum Disorder.

Medically Necessary, as used in this amendment, means based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

Pharmacy Care means medications prescribed by a licensed physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic Care means services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or clinical social workers.

Treatment for Autism Spectrum Disorder shall be identified in a Treatment plan and includes the following care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist who determines the care to be Medically Necessary: (i) Behavioral Health Treatment, (ii) Pharmacy Care, (iii) psychiatric care, (iv) psychological care, (v) Therapeutic Care, and (vi) Applied Behavior Analysis when provided or

supervised by a board certified behavior analyst who shall be licensed by the Board of Medicine. The prescribing practitioner shall be independent of the provider of Applied Behavior Analysis.

Treatment Plan means a plan for the treatment of Autism Spectrum Disorder developed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

II. The Evidence of Coverage, Description of Covered Services is amended to add the following:

Autism Spectrum Disorder

A. Coverage is provided for:

1. The Diagnosis of Autism Spectrum Disorder; and

2. Evidence-based, Medically Necessary Treatment of Autism Spectrum Disorder in Members age two (2) through age ten (10).

B. Benefits for Autism Spectrum Disorder are subject to the following:

1. Benefits for Autism Spectrum Disorder are not subject to any visit limits.

2. Benefits for Applied Behavioral Analysis, under this amendment, will be subject to an annual maximum benefit of $35,000 per Member.

3. Benefits for Applied Behavioral Analysis treatment must be provided or supervised by a board certified behavior analyst who shall be licensed.

4. A Treatment Plan is not required.

C. Authorization.

1. Prior authorization is required for services to the same extent as it is required for other similar services. Prior authorization to determine appropriateness and medical necessity for treatment will be made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered in the Evidence of Coverage. Consult the Description of Covered Services for a detailed description of the Utilization Management Program requirements. Consult the Schedule of Benefits to determine if there will be a penalty for the Member's failure to obtain prior authorization from CareFirst BlueChoice.

2. Prior authorization is not required for Applied Behavioral Analysis services.

D. Reimbursement. Benefits are available to the same extent as benefits provided for other services.

E. Exclusions.

1. Coverage is not provided for services delivered through school services;

2. Applied Behavioral Analysis services are not provided for children under age two (2) or age eleven (11) and older, unless authorized or approved by CareFirst BlueChoice.

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 in this amendment.

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TOTAL CARE AND COST IMPROVEMENT, HEALTH PROMOTION, WELLNESS AND DISEASE MANAGEMENT PROGRAM AMENDMENT

This amendment is effective. If no date is shown, this amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

TABLE OF CONTENTS

The Evidence of Coverage is amended to add the following provisions:

I Definitions.

Biometric Screening means an onsite event during which Member screenings are provided for various measurements, such as: height, weight, BMI, waist circumference, blood pressure, LDL, HDL, total cholesterol, the total cholesterol to HDL ratio, triglycerides, and glucose.

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

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

Disease Management Program means a coordinated, confidential program designed to manage a Member's chronic disease so that action can be taken to improve outcomes in the future.

Disease Management Coaching Session means an interactive coaching session provided to the Member with the Member's consent that furthers the Member's Disease Management Program.

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

Health Promotion and Wellness Program means a coordinated program designed to prevent disease, identify a Member's risk factors for disease or detect early stages of a Member's disease so that action can be taken to prevent poor outcomes in the future.

Primary Care Physician (PCP) means a Preferred Provider, selected by a Member to provide and manage the Member's health care, who is a health care practitioner in the following disciplines:

A. General practice medicine;

B. General internal medicine;

C. Family practice medicine;

D. Pediatric medicine; or

E. Geriatric medicine.

Qualified Member means a Member who:

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

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

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

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

Weight Loss Services means CareFirst BlueChoice approved services available to clinically obese Members for the purpose of achieving measurable weight loss and sustainable weight maintenance, as part of the Health Promotion and Wellness Program.

Wellness Coaching Session means an interactive wellness coaching session provided to the Member with the Member's consent that furthers the Member's Health Promotion and Wellness Program.

II Benefits and Cost Sharing Waiver.

A. Qualified Members are eligible for a waiver of their cost sharing responsibility for benefits provided under this Section when:

1. While in an active plan of care, the Qualified Member participates in either (a) a CCC Program coordinated by the Qualified Member's PCP who participates in CareFirst BlueChoice's Patient-Centered Medical Home Program or (b) a CCM Program coordinated by the Qualified Member's Specialist, or

2. At CareFirst BlueChoice's initiation, and in consultation with and direction from the Qualified Member's treating provider or nurse practitioner, the Qualified Member participates in one or more of the TCCI Program elements outside of a plan of care and without participating in CCM Program or CCC Program.

B. Qualified Members participating in a CCM Program or CCC Program as set forth in Section II.A.1 are eligible for the following CCM Program and CCC Program benefits while in an active plan of care:

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

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

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

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

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

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

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

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

9. Other Medically Necessary services provided to a Qualified Member while in an active plan of care.

C. Qualified Members participating in a CCM Program or CCC Program while in an active plan of care under Section II.A.1 or, pursuant to CareFirst BlueChoice initiation under Section II.A.2, are eligible for benefits under following TCCI Program elements:

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

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

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

4. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in a home-based care management plan. Covered Services provided to a Qualified Member pursuant to a home-based care management plan under this section will not count toward any visit limits stated in the Schedule of Benefits.

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

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

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

D. Qualified Member Cost Sharing Responsibilities.

1. Under this section, any applicable cost-sharing responsibilities will be waived for (i) TCCI Program services provided by a Designated Provider and (ii) in-network services provided to Qualified Members in an active plan of care.

Cost-sharing responsibilities are not waived for any (i) prescription or other drug benefits; (ii) services provided in an inpatient institution or facility; or (iii) services provided in a hospital.

2. If the Qualified Member's Evidence of Coverage is compatible with a federally-qualified Health Savings Account:

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

(2) If the Qualified Member has not funded his/her HSA account during the Benefit Period, then if the Qualified Member agrees not to fund his/her HSA account and provides a signed agreement not to fund his/her HSA account, then the Qualified Member will be eligible for the waiver described in II.D.1.

E. Termination.

1. The Qualified Member's participation in the TCCI Program(s) and receipt of benefits and cost-sharing waivers under this Section will be terminated under the following circumstances:

a) The Qualified Member completes the stated goals of the TCCI Program(s) set forth in the Qualified Member's plan of care and confirmed by the Qualified Member's treating physician or nurse practitioner or, if the TCCI Program(s) benefits are provided to Members not in an active plan of care, when confirmed by the Qualified Member's treating physician or nurse practitioner.

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

c) The Qualified Member's coverage under this Evidence of Coverage is terminated.

2. If termination is the result of the Qualified Member's failure to comply with the TCCI Program(s) under Section II.E.1.(b), the Qualified Member will be provided the opportunity to comply with the TCCI Program(s) during the thirty (30) day notice period. If after consultation between the Qualified Member's treating physician or nurse practitioner and the CareFirst BlueChoice designated nurse, provider, or care coordinator a determination is made that the Qualified Member is not and will not be compliant with the applicable TCCI Program(s), the Qualified Member will receive a final written notice of termination of benefits under this Section.

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

III Health Promotion and Wellness.

1. Health Assessments are available for all adult Members.

2. Benefits are available for Biometric Screening of Members, as defined above.

3. Lifestyle Coaching Session services are available as follows:

   a. With the Member's consent, an initial discussion with a lifestyle coach to establish defined goal(s) for wellness coaching, and to determine the frequency of future coaching sessions in order to best meet the goal(s) established.

   b. After the initial discussion, Coaching Sessions to track, support, and advance the Member's wellness/lifestyle goal(s).

4. Other Wellness Program benefits are available, which may include tobacco-cessation, well-being challenges, and financial well-being improvement programs.

5. Weight Loss Services are available to clinically obese Members, as follows:

   a. A clinically obese Member is a Member whose Body Measurement Index (BMI) score is greater than thirty (30).

   b. A dedicated, CareFirst BlueChoice approved coach is assigned to the Member to assist the Member in the development of healthy eating habits, physical activity habits, and to address the emotional, social, and environmental aspects shown to be important for sustained weight loss.

   c. The Members receive one-on-one telephonic interventions with the coach and online educational resources, robust food, exercise trackers, recipes, peer-to-peer communication, and group community features for complete social support and accountability.

IV Disease Management.

1. Disease Management services, which may include a Disease Management Program to help the Member understand his/her disease and health status and physician treatment plans, individual and family education regarding the disease, treatment compliance and self-care techniques, and help to organize care for the disease, including arranging for needed services and supplies.

2. Disease Management Coaching Session services are available as follows:

   a. With the Member's consent, an initial discussion with a coach to establish defined goal(s) for disease management coaching, and to determine the frequency of future coaching sessions in order to best meet the established goal(s) and manage the disease.

   b. After the initial discussion, Disease Management Coaching Sessions to track, support, and advance the Member's disease management goal(s).

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

CareFirst BlueChoice, Inc.

Chester E. Burrell
President and Chief Executive Officer

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An independent licensee of the Blue Cross and Blue Shield Association

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES AMENDMENT REVISED

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

The Evidence of Coverage is amended as follows:

I. The introduction to Section 6, Mental Health and Substance Abuse Services, of the Description of Covered Services, is deleted and replaced with the following:

SECTION 6
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In Contracting Provider's offices or in other CareFirst BlueChoice approved; or	Coverage for the outpatient services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits
In a CareFirst BlueChoice approved Hospital or Qualified Substance Abuse Treatment Facility, when admitted under the care of a Contracting Physician.	Coverage for the inpatient services listed below. The coverage is subject to the limitations, if any, stated in the Schedule of Benefits.	Deductible, Copayments or Coinsurance, if any, required under the Member's coverage as stated in the Schedule of Benefits

II. Section 6.2, Outpatient Mental Health and Substance Abuse Services, of the Description of Covered Services is deleted and replaced with the following:

6.2 Outpatient Mental Health and Substance Abuse Services. CareFirst BlueChoice will review and evaluate claims for Outpatient Mental Health and Substance Abuse services to assess the Medical Necessity and appropriateness of the services. CareFirst BlueChoice will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment. Benefits will be provided for:

A. Coverage of mental illness, emotional disorders, drug abuse and alcohol abuse. Services include evaluation, diagnosis and treatment of acute and non-acute conditions.

B. Medication management visits in connection with mental illness, emotional disorders, alcohol abuse and drug abuse will be covered in the same manner as medication management visits for physical illnesses. Members are not required to obtain prior authorization or referrals from a Primary Care Physician for methadone maintenance treatment.

C. Substance abuse and related mental health conditions including detoxification and rehabilitative services in a CareFirst BlueChoice designated program.

D. Other covered medical and medical Ancillary Services for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

E. Partial hospitalization provided through a Qualified Partial Hospitalization Program.

III. The provisions of Section 6, Mental Health and Substance Abuse Services, of the Schedule of Benefits, relating to Outpatient Services, Medication Management and Partial Hospitalization are deleted and replaced with the following:

Service	Limit on Benefits	Subject to Deductible	Member Payment
SECTION 6 - MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES			
Outpatient Mental Health and Substance Abuse Services			
Office Visits		Yes	No Copayment or Coinsurance
Outpatient Facility Services		Yes	No Copayment or Coinsurance
Professional Services Provided at an Outpatient Facility		Yes	No Copayment or Coinsurance
Medication Management		Yes	No Copayment or Coinsurance
Methadone Maintenance		Yes	No Copayment or Coinsurance
Partial Hospitalization Program Facility Services		Yes	No Copayment or Coinsurance
Professional Services Provided in a Partial Hospitalization Program		Yes	No Copayment or Coinsurance

IV. All Outpatient Mental Health and Substance Abuse Services and Inpatient Mental Health and Substance Abuse Services visit or day limitations are removed.

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 BlueChoice, Inc.

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2017 AMENDMENT

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

TABLE OF CONTENTS

The Evidence of Coverage is amended as follows:

SECTION A - DEFINITIONS

1. The definition of "Allowed Benefit" in Section 1 of the Evidence of Coverage is deleted and replaced with the following:

Allowed Benefit means:

A. For a Contracting- Provider, the Allowed Benefit for a Covered Service is the amount agreed upon between CareFirst BlueChoice and the Contracting Provider which, in some cases, will be a rate set by a regulatory agency. The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance amounts, for which the Member is responsible.

B. For a Non-Contracting Provider that is a health care practitioner, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the provider at the discretion of CareFirst BlueChoice. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the practitioner's actual charge. The provider may bill the Member directly for such amounts. It is the Member's responsibility to apply any CareFirst BlueChoice payments to the claim from the Non-Contracting Provider charge.

C. For a Non-Contracting Provider that is a health care facility, the Allowed Benefit for a Covered Service is based upon either the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the facility, at the discretion of CareFirst BlueChoice. Benefit payments to Department of Defense and Veteran Affairs providers will be made directly to the provider. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the

provider's actual charge. It is the Member's responsibility to apply any CareFirst BlueChoice payments to the claim from the Non-Contracting Facility.

In some cases, and on an individual basis, CareFirst BlueChoice is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst BlueChoice payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment, or Coinsurance amounts, for which the Member is responsible.

D. For a Covered Service rendered by a Non-Contracting Provider of ambulance services, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or the established fee schedule. The benefit is payable to the Non-Contracting Provider of ambulance services that is a Virginia emergency medical services vehicle, as defined by Virginia Code § 38.2-3407.9, and that accepts an assignment of benefits and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance amounts as stated in the Schedule of Benefits. For other Non-Contracting Providers of ambulance services, the Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the provider's actual charge. The provider may bill the Member directly for such amounts. When an assignment of benefits is not accepted, benefits will be paid to the Member. It is the Member's responsibility to apply any CareFirst BlueChoice payments to the claim from the Non-Contracting Provider of ambulance services.

For Emergency Services provided by a Non-Contracting Provider, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge, or the amount that would be paid to a Contracting Provider for the Covered Service. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the practitioner's actual charge. The provider may bill the Member directly for such amounts.

2. The following definition of "Prescription Drugs" is added to Section 1, Definitions:

Prescription Drug means

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

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

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

D. Any Diabetic Supply.

E. Prescription Drugs do not include:

1. Compounded bulk powders that contain ingredients that:

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

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

c) Do not require a prescription to be dispensed.

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

a) There is no commercially available bio-equivalent Prescription Drug; OR

b) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

3. All references to "Prior Authorization List" in the Evidence of Coverage are replaced with "Prescription Guidelines".

The following definition of "Prior Authorization List" is added to Section 1, Definitions :

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

4. All references to "Preferred Preventive Drug" in the Evidence of Coverage are replaced with "Preventive Drug".

The following definition of "Preventive Drug" is added to Section 1, Definitions:

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

5. All references to "Preferred Preventive Drug List" in the Evidence of Coverage are replaced with "Preventive Drug List".

The following definition of "Preventive Drug List" is added to Section 1, Definitions:

Preventive Drug List means the list issued by CareFirst BlueChoice of Prescription Drugs or Over-the-Counter medications or supplies dispensed under a written prescription by a health care provider that have been identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration. CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Preventive Drug List is available to the Member upon request.

SECTION B - ELIGIBILITY OF DEPENDENT CHILDREN

All provisions of the Evidence of Coverage that define or describe Eligibility of Dependent Children are revised as follows:

A Dependent Child means an individual who:

A. Is:

1. The natural child, stepchild, adopted child, or foster child of the Subscriber;

2. A child placed with the Subscriber or the Subscriber's covered Spouse for legal Adoption;

3. A child under testamentary or court appointed guardianship, other than temporary guardianship for less than twelve (12) months' duration, of the Subscriber or the Subscriber's covered Spouse;

4. An unmarried grandchild who is in the court-ordered custody, and who resides with and is a dependent of the Subscriber or Spouse; or

5. A child who becomes a Dependent of the Subscriber through a child support order or other court order.

SECTION C - PROOF OF LOSS

Section 6.2 B., Proof of Loss, of the Evidence of Coverage is deleted and replaced with the following:

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

CareFirst BlueChoice 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 BlueChoice before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst BlueChoice deems necessary to process the claims. CareFirst BlueChoice provides forms for this purpose.

SECTION D - MEMBER PRIVACY

Section 6.9, Member Privacy, of the Evidence of Coverage deleted and replaced with the following:

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

SECTION E - CREDIT MONITORING

The following provision is added to the Evidence of Coverage, General Provisions section:

CareFirst BlueChoice is offering credit monitoring to you and eligible Dependents at no additional charge through services administered by Experian. Credit monitoring is available on an opt-in basis for all eligible Members and Dependents during the effective Benefit Period of their CareFirst BlueChoice health insurance policy. To sign up, please call the number on the Member's ID card or visit www.carefirst.com.

SECTION F - SERVICE AREA

Section 7, Service Area, of the Evidence of Coverage is deleted and replaced with the following:

SECTION 7
SERVICE AREA

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

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

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

SECTION G - MEDICAL ADVICE LINE - EMERGENCY SERVICES

The following is added to Section 7, Emergency Services and Urgent Care, of the Description of Covered Services:

Benefits are available to a Member for Emergency Services and Urgent Care on a twenty-four (24) hour basis and include access to medical care, or access by telephone to a physician or licensed health care provider with appropriate medical training who can refer or direct a Member for prompt medical care when there is an immediate need or Medical Emergency. In the case of a Medical Emergency call 911 or go to the emergency room. When a Member has a health problem or an urgent medical condition, the Member should contact his or her Primary Care Physician at the phone number stated on the Identification Card. If the Member cannot reach his or her PCP, FirstHelp™, a 24 hours a day, 7 days a week health care advice line is available to assist in making a decision concerning the most appropriate level of care. FirstHelp™ may be reached at 800- 535-9700 (toll-free). FirstHelp™ is solely responsible for the advice services. Benefits for Emergency Services, Urgent Care, and follow-up care after emergency surgery are provided regardless of where Covered Services are provided.

SECTION H - EXCLUSIONS AND LIMITATIONS

The following exclusion is removed and deleted from any and all portions of the Evidence of Coverage, specifically in the Description of Covered Services Section:

11.1N. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.

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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INTER-PLAN ARRANGEMENTS DISCLOSURE AMENDMENT

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

Out-of-Area Services

Overview

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

Typically, when accessing care outside the geographic area CareFirst BlueChoice serves, Members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. CareFirst BlueChoice remains responsible for fulfilling our contractual obligations to you. CareFirst BlueChoice payment practices in both instances are described below.

CareFirst BlueChoice covers only limited healthcare services received outside of its Service Area. As used in this section "Out-of-Area Covered Healthcare Services" means:

1. Emergency Services;
2. Urgent Care;
3. Follow-up care after emergency surgery for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and

obtained outside the geographic area CareFirst BlueChoice serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements unless authorized by CareFirst BlueChoice.

Inter-Plan Arrangements Eligibility - Claim Types

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

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Out-of-Area Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its participating providers.

The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of the Member liability on claims for Out-of-Area Covered Services processed through the BlueCard Program will be based on the lower of the provider's billed covered charges or the negotiated price made available to CareFirst BlueChoice by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to CareFirst BlueChoice by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim-and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether or not it will use an actual price, an estimated price or an average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price the Member pays on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, CareFirst BlueChoice will include any such surcharge, tax or other fee in the group premium.

Return of Overpayments

Recoveries of overpayments from a Host Blue or its participating and nonparticipating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recovery amounts determined in the ways noted above will be applied so that corrections will be made, in general, on a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to CareFirst BlueChoice, they will be credited to the group account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to the group account as a percentage of the recovery.

B. Nonparticipating Providers Outside CareFirst BlueChoice Service Area

1. Member Liability Calculation

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

2. Exceptions

In some exception cases, at the group's direction, CareFirst BlueChoice may pay claims from nonparticipating providers for Out-of Area Covered Healthcare Services based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to a participating provider, as determined by CareFirst BlueChoice in our sole and absolute discretion, or by applicable state law. In other exception cases, CareFirst BlueChoice may pay such a claim based on the payment CareFirst BlueChoice would make if we were paying a nonparticipating provider for the same covered healthcare services inside of The CareFirst BlueChoice Service Area, as described elsewhere in this contract. This may occur where the Host Blue's corresponding payment would be more than CareFirst BlueChoice in-service area nonparticipating provider payment. CareFirst BlueChoice may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment CareFirst BlueChoice will make for the covered services as set forth in this paragraph.

C. Blue Cross Blue Shield Global Core

General Information

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

- **Inpatient Services**

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient hospital services, except for their deductibles, coinsurance, etc. In such cases, the Blue Cross Blue Shield Global Core contracting hospital will submit Member claims to the Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services. **Members must contact CareFirst BlueChoice to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

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

- **Submitting a BlueCard Worldwide Claim**

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

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

CareFirst BlueChoice, Inc.

Chester E. Burrell
President and Chief Executive Officer

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840 First Street, NE
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An independent licensee of the Blue Cross and Blue Shield Association

INTER-PLAN ARRANGEMENTS DISCLOSURE AMENDMENT

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

Out-of-Area Services

Overview

CareFirst BlueChoice has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside of CareFirst BlueChoice service area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of CareFirst BlueChoice service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee/Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. CareFirst BlueChoice explains below how we pay both kinds of providers.

CareFirst BlueChoice covers only limited healthcare services received outside of its Service Area. As used in this section "Out-of-Area Covered Healthcare Services" means:

1. Emergency Services;
2. Urgent Care;
3. Follow-up care after emergency surgery for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed, and

obtained outside the geographic area CareFirst BlueChoice serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements unless authorized by CareFirst BlueChoice .

Inter-Plan Arrangements Eligibility - Claim Types

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

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under the BlueCard® Program, when you receive Out-of-Area Covered Services within the geographic area served by a Host Blue, CareFirst BlueChoice will remain responsible for doing what we agreed to in the contract. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member copayment amount, as stated in your Plan Summary.

Emergency Care Services: If you experience a Medical Emergency while traveling outside the CareFirst BlueChoice service area, go to the nearest Emergency or Urgent Care facility.

When you receive Out-of-Area Covered Healthcare Services outside the CareFirst BlueChoice Service Area and the claim is processed through the BlueCard Program, the amount you pay for the Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed charges for your Out-of-Area Covered Healthcare Services; or
- The negotiated price that the Host Blue makes available to CareFirst BlueChoice.

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

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

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

B. Nonparticipating Providers Outside CareFirst BlueChoice Service Area

1. Your Liability Calculation

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

2. Exceptions

   In certain situations, CareFirst BlueChoice may use other payment methods, such as billed charges for Out-of-Area Covered Healthcare Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount CareFirst BlueChoice will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment CareFirst BlueChoice will make for the Out-of-Area Covered Healthcare Services as set forth in your contract.

C. Blue Cross Blue Shield Global Core

If you are outside the United States, you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

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

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact CareFirst BlueChoice to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

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

- **Submitting a BlueCard Worldwide Claim**

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

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

CareFirst BlueChoice, Inc.

Chester E. Burrell
President and Chief Executive Officer

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202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

2018 AMENDMENT

This amendment is effective. If no date is shown, this amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

TABLE OF CONTENTS

SECTION A – DEFINITIONS

As used in this amendment, the following definitions are added to Section 1 of the Evidence of Coverage:

Enhanced Monitoring Program (EMP) means the CareFirst BlueChoice program for Members with a chronic condition or disease for which medical equipment and monitoring services are provided to help the Member manage the chronic condition or disease.

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

Substance Use Disorder means:

A. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or

B. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Substance Use Disorder Program means the CareFirst BlueChoice program for Members with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

SECTION B – RETROACTIVE TERMINATION OF MEMBERS

Section VII. E, Retroactive Termination of Members, in the Group Contract is deleted and replaced with the following:

E. Retroactive Termination of Members. When the Group fails to provide prospective notice of a Member's termination, CareFirst BlueChoice will only retroactively terminate a Member's coverage at 11:59 p.m., Eastern Time, on the last day of the month prior to the month in which the notice of termination is received by CareFirst BlueChoice or; if claims for services rendered after the requested termination have been received and processed, the day after the service date. For example, if CareFirst BlueChoice receives retrospective notice of termination on December

16, CareFirst BlueChoice will only retroactively terminate a Member's coverage to November 30. However, if claim **for a service date** has been received and processed after such date, then CareFirst BlueChoice will terminate coverage the day after such service date. For example, **if claims for service date of** December 5 is received and processed, termination will be December 6.

The Group agrees to indemnify and hold harmless CareFirst BlueChoice, 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 creditable 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.

SECTION C – ENHANCED MONITORING PROGRAM

Section 1, Outpatient and Office Services, in the Description of Covered Services, is amended to add the following:

Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Member who qualifies under the EMP as determined by CareFirst BlueChoice.

There is no Copayment or Coinsurance associated with services provided under this program. Except for Health Savings Account (HSA)-compatible plans to which the Member has contributed to his/her HSA during the Benefit Period, the Deductible, if any, does not apply to Covered Service provided under this provision.

SECTION D – EXPERT CONSULTATION PROGRAM

Section 1, Outpatient and Office Services, in the Description of Covered Services, is amended to add the following:

Expert Consultation Program (ECP). Benefits will be provided for a Member who qualifies as determined by CareFirst BlueChoice for a review by a team of specialists of a Member's medical records.

There is no Copayment or Coinsurance associated with services provided under this program. Except for Health Savings Account (HSA)-compatible plans to which the Member has contributed to his/her HSA during the Benefit Period, the Deductible, if any, does not apply to Covered Service provided under this provision.

SECTION E – SUBSTANCE USE DISORDER PROGRAM

All references to "Substance Abuse" in the Evidence of Coverage are deleted and replaced with "Substance Use Disorder".

Section 6, Mental Health and Substance Use Disorder Services, in the Description of Covered Services, is amended to add the following:

Substance Use Disorder Program.

A. Program benefits will be provided for outpatient treatment of Substance Use Disorder in accordance with the Substance Use Disorder Program if:

1. The Member qualifies for the Substance Use Disorder Program, as determined by CareFirst BlueChoice.

2. The Member receives treatment from a recognized treatment center of excellence, as determined by CareFirst BlueChoice;

3. Treatment is rendered though an intensive outpatient program (IOP) or an outpatient program at a recognized center of excellence as determined by CareFirst BlueChoice.

B. There is no Copayment or Coinsurance associated with services provided under this program. Except for Health Savings Account (HSA)-compatible plans to which the Member has contributed to his/her HSA during the Benefit Period, the Deductible, if any, does not apply to Covered Service provided under this provision.

SECTION F – EXCLUSIONS AND LIMITATIONS

Section 10.1 HH, Exclusions and Limitations, in the Description of Covered Services is deleted and replaced with the following:

HH. Services required solely for administrative purposes, for example, employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

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 BlueChoice, Inc.

Chester E. Burrell
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840 First Street, NE
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PATIENT PROTECTION DISCLOSURE NOTICE

Primary Care Provider Designation

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

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

Obstetrics and Gynecological Care

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

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NOTICE AMENDMENT

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

The Evidence of Coverage Important Information Concerning This Evidence of Coverage on the cover page is amended to add the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event the Subscriber needs to contact someone about this insurance for any reason, the Subscriber should contact their agent. If no agent was involved in the sale of this insurance, or if the Subscriber has additional questions, the Subscriber may contact the insurance company issuing this insurance at the following address: 840 First Street, NE, Washington, DC 20065, and telephone number: 202-479-8000.Written correspondence is preferable so that a record of the Subscriber's inquiry is maintained. When contacting the agent, company or the Bureau of Insurance, the Subscriber should have their policy number available.

If the Subscriber has been unable to contact or obtain satisfaction from CareFirst BlueChoice or the agent, the Subscriber may contact the Virginia State Corporation Commission's Bureau of Insurance at the address and phone number provided in the Benefit Determinations and Appeals document (Attachment A).Written correspondence is preferable so that a record of the inquiry is maintained. When contacting the agent, company or the Bureau of Insurance, have the policy number available.

CareFirst BlueChoice recommends that the Subscriber familiarize himself or herself with CareFirst BlueChoice's Benefit Determinations and Appeals document (Attachment A), and make use of it before taking any other action.

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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PRESCRIPTION DRUG BENEFITS RIDER

This rider is issued by CareFirst BlueChoice 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.

This rider contains specific exclusions and limitations applicable to Prescription Drug benefits that are in addition to the exclusions contained in the Evidence of Coverage to which this rider is attached.

Members are required in all instances, except in the case of emergency services or an out-of-area urgent care situation, to receive Prescription Drugs from a Contracting Pharmacy.

TABLE OF CONTENTS

A. DEFINITIONS. In addition to the definitions contained in the Evidence of Coverage to which this rider is attached, the underlined terms below, when capitalized, have the following meanings:

Prescription Drug Allowed Benefit, as used in this rider, means:

The Prescription Drug Allowed Benefit for Covered Prescription Drugs is the lesser of:

1. The Pharmacy's actual charge; or

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

For Covered Prescription Drugs or Diabetic Supplies obtained from a non-Contracting Pharmacy, either in cases of Emergency Services or out-of-area Urgent Care only, the non-Contracting Pharmacy's actual charge.

Benefit Period, as used in this rider, means the period of time during which Covered Prescription Drug benefits are eligible for payment. The Benefit Period will be the same as the Benefit Period stated in the Evidence of Coverage to which this rider is attached.

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.

Coinsurance, as used in this rider, means the percentage of the Prescription Drug Allowed Benefit allocated between CareFirst BlueChoice and the Member, whereby CareFirst BlueChoice and the Member share in the payment for Covered Prescription Drugs.

Contracting Pharmacy, as used in this rider, means the separate independent Pharmacist or Pharmacy that has contracted with CareFirst BlueChoice or its designee to provide Prescription Drugs in accordance with the terms of this rider.

Copayment (Copay), as used in this rider, means a fixed dollar amount that a Member must pay for certain Covered Prescription Drugs.

Covered Prescription Drug means a Prescription Drug included in the CareFirst BlueChoice Formulary.

Covered Specialty Drug means a Specialty Drug included in the CareFirst BlueChoice Formulary.

Diabetic Supplies means all Medically Necessary and appropriate supplies prescribed by a health care provider for the treatment of diabetes.

Formulary means the means the list of Prescription Drugs issued by CareFirst BlueChoice and used by health care providers when writing, and Pharmacists, when filling, prescriptions for which coverage will be provided under this Agreement. CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Formulary is available to the Member upon request.

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 being required for six (6) months or more to treat a chronic condition.

Non-Preferred Brand Name Drug means a Prescription Drug included in the Formulary as a Covered Prescription Drug but not included in the Preferred Drug List.

Non-Preferred Specialty Drug means a Covered Specialty Drug included in the Formulary as a Covered Prescription Drug but not included on the Preferred Drug List.

Over-the-Counter, as used in this rider, means medications and supplies that may be purchased without a prescription.

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

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

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

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

Preferred Specialty Drug means a Covered Specialty Drug included in the Preferred Drug List.

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

Preventive Drug List means a Prescription Drug, including an Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is included on the list issued by CareFirst BlueChoice of the items identified in the current recommendations of the United States

Preventive Services Task Force that have in effect a rating of "A" or "B" or as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration. A copy of the Preventive Drug List is available to Members upon request.

Prescription Drug means:

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

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

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

D. Any Diabetic Supply.

E. Prescription Drugs do not include:

1. Compounded bulk powders that contain ingredients that:

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

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

c) Do not require a prescription to be dispensed.

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

a) There is no commercially available bio-equivalent Prescription Drug; OR

b) The commercially available bio-equivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

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

Prior Authorization List means the limited list of Prescription Drugs issued by CareFirst BlueChoice for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from CareFirst BlueChoice. A copy of the Prior Authorization List is available to Members upon request.

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

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

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

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

D. Requires:

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

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

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

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

a) may have no known cure;

b) is progressive; or

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

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

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

b) approximately 1 in 1,500 individuals worldwide.

B. PRESCRIPTION DRUG BENEFITS

1. Benefits will be provided for a Prescription Drug dispensed by a Contracting Pharmacy for self-administered-use on an outpatient basis for the treatment of a condition for which benefits are provided under the terms of the Evidence of Coverage.

2. CareFirst BlueChoice or its designee reserves the right to substitute a Generic Drug for any Brand Name Drug unless otherwise indicated on the prescription order.

3. Dispensing.

a) Members may obtain up to a thirty-four (34) day supply of a non-Maintenance Drug from a Contracting Pharmacy or through the mail order program.

b) Members may also obtain up to a ninety (90) day supply of a Maintenance Drug from a Contracting Pharmacy or through the mail order program.

c) Coverage will be provided for up to a twelve (12)-month supply of prescription contraceptives when dispensed at one time to the Member by a pharmacy provider

Members must use 80% of a dispensed non-Maintenance Drug or Maintenance Drug in the manner prescribed before a refill of that prescription can be obtained.

4. A Member may select a Prescription Drug that is not included on the Preferred Drug List. In addition to the non-Preferred Brand Name Drug Copayment or Coinsurance, an additional penalty will apply if the non-Preferred Brand Name Drug is a Brand Name Drug that has a Generic Drug equivalent. If a Member selects a non-Preferred Brand Name Drug when a Generic Drug is available, the Member will pay the non-Preferred Brand Name Drug Copayment or Coinsurance plus the difference between the price of the non-Preferred Brand Name Drug and the Generic Drug up to the cost of the prescription. This Generic Drug penalty will not apply to the Member's Deductible or Out-of-Pocket Maximum.

5. If a provider prescribes, and the Member selects, a Non-Preferred Brand Name Drug, when a Generic Drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug. A Member will be allowed to obtain a Non-Preferred Brand Name Drug in place of an available Generic Drug and pay only the Non-Preferred Brand Name Drug Copayment when Medically Necessary, as determined by CareFirst BlueChoice.

6. Members or health care providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Covered Prescription Drug in the Prescription Guidelines. A copy of the Prescription Guidelines is available to the Member or provider upon request.

7. **Payment of Claims and Timely Filing**: If the Member purchases a covered Prescription Drug 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 Deductible, Copayment, or Coinsurance as stated in this rider. The Member is responsible for any applicable Deductible, Copayment or Coinsurance and the Contracting Pharmacy may bill the Member directly for such amounts.

   In cases of Emergency Services or Out-of-Area Urgent Care situations, if the Member purchases a covered Prescription Drug from a non-Contracting Pharmacy, the Member is responsible for paying the total charge and submitting a claim to CareFirst BlueChoice or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst BlueChoice or its designee up to the amount of the Allowed Benefit, minus any applicable Deductible, Copayment or Coinsurance. Members may be responsible for balances above the Prescription Drug Allowed Benefit. However, if the non-Contracting Provider or its intermediary agrees in prior written notification to CareFirst to accept reimbursement at the same rate as a Contracting Provider, including any Copayments or Coinsurance, then the Member will not be responsible for balances above the Allowed Benefit.

   All claims submitted to CareFirst BlueChoice or its designee for Prescription Drugs purchased at a non-Contracting Pharmacy must be submitted within one (1) year after the date the Prescription Drug was dispensed. CareFirst BlueChoice or its designee will only consider claims beyond the one (1) year filing period if the Member became legally incapacitated prior to the end of the filing period.

8. Benefits include:

   a Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. Coverage for procedures for insertion or removal and any Medically Necessary examinations associated with the use of such contraceptive drugs or devices shall be provided under the medical benefits outlined in the Evidence of Coverage.

   b. Human growth hormones. Prior authorization is required.

   c. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Formulary.

   d. Injectable medications that are self-administered and the prescribed syringes and needles.

   e. Standard covered items such as insulin, glucagon and anaphylaxis kits.

f. Fluoride products.

g. Diabetic Supplies: lancets, alcohol wipes, test strips (blood and urine), syringes and needles.

h. Infertility drugs or agents except for use in connection with infertility services or treatments excluded from coverage under the Evidence of Coverage.

i. Oral chemotherapy drugs.

9. Coverage of Medically Necessary Prescription Drugs Not Included in the CareFirst BlueChoice Formulary

a. Members may request an exception for coverage of a Medically Necessary Prescription Drug not contained in the CareFirst BlueChoice Formulary under the following circumstances:

i) If the Formulary drug is determined by CareFirst BlueChoice, after reasonable investigation and consultation with the prescribing provider, to be an inappropriate therapy for the medical condition of the Member.

ii) When the Member has been receiving the non-Formulary drug for at least 6 months prior to the revision of the Formulary, and the prescribing provider has determined that the Formulary drug is an inappropriate therapy for the Member, or that changing drug therapy presents a significant health risk to the Member.

b. Process to Obtain Medically Necessary Prescription Drugs Not Included in the CareFirst BlueChoice Formulary:

i) The Member, the Member's authorized representative, or the Member's provider may request an exception based upon Medical Necessity by contacting CareFirst BlueChoice at the telephone number located on the back of the Member's identification card.

ii) An exception request form should be submitted by the prescribing provider to CareFirst BlueChoice. The prescribing provider may also submit a letter of Medical Necessity for dispensing of the non-Covered Prescription Drug.

iii) All exception requests will be reviewed and acted upon by CareFirst BlueChoice within one (1) business day of the receipt of the request.

iv.) Upon review by CareFirst BlueChoice, the prescribing provider and the Member will be notified of the coverage determination as follows:

1. For a standard exception request, notification of the coverage determination will be provided to the Member and the prescribing provider within 72 hours following the receipt of the request.

2. For an expedited exception request (based on exigent circumstances), notification of the coverage determination will be provided to the Member and the prescribing provider within 24 hours following the receipt of the request.

For purposes of this provision, exigent circumstances exist when a Member is suffering from a health condition that may seriously

jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a non-Formulary Prescription Drug.

c. Outcome of Review

i) If the request is approved, the Prescription Drug will be dispensed and the Member will be responsible for the Non-Preferred Brand Name Drug Copayment. If the Prescription Drug exception request is for a non-Formulary Specialty Drug and the exception is granted, the Member will be responsible for the Non-Preferred Specialty Drug Copayment. CareFirst BlueChoice shall provide coverage for the non-Formulary drug for the duration of the prescription (including refills) if coverage is granted under a standard exception request, or for the duration of the exigency if coverage is granted under an expedited exception request.

ii) If the exception request is denied, the denial shall be considered an Adverse Decision and may be appealed in accordance with the process outlined in the Benefit Determination and Appeals section of the Evidence of Coverage.

iii) If the exception request is denied, the Member or the prescribing provider may submit an external exception request to CareFirst BlueChoice, requiring that the original exception request and subsequent denial be reviewed by an independent review organization. Such requests shall be reviewed and a coverage determination provided to the Member and the prescribing provider within 72 hours following the receipt of the request if the original request was a standard exception request, or 24 hours following the receipt of the request if the original request was an expedited exception request.

C. BENEFITS FOR SPECIALTY DRUGS

Benefits for Covered Specialty Drugs are available when purchased by mail order.

D. MAIL ORDER PROGRAM

Members have the option of ordering Prescription Drugs via mail order. The mail order program provides Members with a Pharmacy that has an agreement with CareFirst BlueChoice or its designee, to provide mail service for Covered Prescription Drugs in accordance with the terms of this provision. Members will be responsible for the Copayment or Coinsurance as outlined in Section E, Copayments and Coinsurance, below.

E. COPAYMENTS AND COINSURANCE

Subject to the limitations and conditions stated in the limitations column and in the numbered paragraphs below, Covered Prescription Drugs and Covered Specialty Drugs are subject to the following Copayment or Coinsurance.

SERVICE	LIMITATIONS	MEMBER PAYS
Prescription Drugs – Non-Maintenance Drugs	Limited to a 34-day supply of Prescription Drugs. This provision does not apply to covered Specialty Drugs.	**Preventive Drugs, Diabetic Supplies and Oral Chemotherapy Drugs:** No Copayment or Coinsurance **Generic Drugs:** $10 Copayment per prescription or refill **Preferred Brand Name Drugs:** $25 Copayment per prescription or refill. **Non-Preferred Brand Name Drugs:** $45 Copayment per prescription or refill.
Prescription Drugs - Maintenance Drugs	Limited to a 90-day supply of Prescription Drugs. This provision does not apply to covered Specialty Drugs.	**Preventive Drugs, Diabetic Supplies and Oral Chemotherapy Drugs:** No Copayment or Coinsurance **Generic Drugs:** $20 Copayment per prescription or refill. **Preferred Brand Name Drugs:** $50 Copayment per prescription or refill. **Non-Preferred Brand Name Drugs:** $90 Copayment per prescription or refill.
Specialty Drugs	Benefits for Covered Specialty Drugs are available when purchased by mail order. This provision does not apply to injectable medications.	**Preferred Specialty Drugs:** 50% up to a Member maximum payment of $100 per prescription or refill for up to a 34-day supply of a non-Maintenance Drug 50% up to a Member maximum payment of $200 per prescription or refill for up to a 90-day supply of a Maintenance Drug **Non-Preferred Specialty Drugs:** 50% up to a Member maximum payment of $150 per prescription or refill for up to a 34-day supply of a non-Maintenance Drug 50% up to a Member maximum payment of $300 per prescription or refill for up to a 90-day supply of a Maintenance Drug

1. The Member must pay the Copayment or Coinsurance at the time that a prescription is filled by the Pharmacist.

2. Contraceptive drugs and devices on the Preferred Preventive Drug List are not subject to a Copayment or Coinsurance.

3. If the cost of the Prescription Drug is less than the Copayment or Coinsurance stated above, then the cost of the Prescription Drug will be payable by the Member at the time the prescription is filled.

F. DRUG DEDUCTIBLE

1. All Covered Prescription Drugs or other covered items under this rider, except for the items listed below, are subject to the applicable Deductible stated in the Schedule of Benefits of the Evidence of Coverage to which this rider is attached. Amounts paid by the Member for Covered Prescription Drug(s) or other covered items under this rider that are subject to the Deductible will be applied to the Deductible stated in the Schedule of Benefits of the Evidence of Coverage to which this rider is attached. Unless, the applicable Out-of-Pocket Maximum stated in the Schedule of Benefits in the Evidence of Coverage to which this rider is attached has otherwise been met, the Member must pay the entire cost of the Prescription Drug(s) or other items covered under this rider, until the Deductible is satisfied. Once the Deductible has been satisfied, the Member will pay the applicable Copayment or Coinsurance.

2. The following Prescription Drugs, or other items covered under this rider, are not subject to the Deductible stated in the Schedule of Benefits:

   Preventive Drugs.

3. The following amounts may not be used to satisfy the Deductible stated in the Schedule of Benefits:

   a. Charges in excess of the Allowed Benefit paid to a non-Contracting Pharmacy.

   b. Amounts incurred for Prescription Drugs, including Specialty Drugs that are excluded from coverage under this rider.

   c. Copayments or Coinsurance incurred by the Member for Covered Prescription Drugs not subject to the Deductible.

   d. Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.

   e. Amounts incurred, or that would have been incurred, by the Member for failure to comply with prior authorization requirements for a Prescription Drug on the Prescription Guidelines.

   f. Discounts, coupons, or other amounts from third parties, including manufacturer coupons and discount prescription card programs.

G. OUT-OF-POCKET MAXIMUM

1. Amounts paid by the Member for the Covered Prescription Drugs or other covered items provided under this rider will be applied to the Out-of-Pocket Maximum stated in Schedule of Benefits of the Evidence of Coverage to which this rider is attached. Once the Out-of-Pocket Maximum has been reached, the Member will no longer be required to pay any Deductible, Copayment or Coinsurance for benefits under this rider.

2. The following amounts may not be used to satisfy Out-of-Pocket Maximum stated in the Schedule of Benefits of the Evidence of Coverage to which this rider is attached:

   a. Charges in excess of the Allowed Benefit paid to a non-Contracting Pharmacy.

   b. Amounts incurred for Prescription Drugs, including Specialty Drugs that are excluded from coverage under this rider.

c. Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.

d. Amounts incurred by the Member for failure to comply with prior authorization requirements for a Prescription Drug in the Prescription Guidelines.

e. Discounts, coupons, or other amounts from third parties, including manufacturer coupons and discount prescription card programs.

H. EXCLUSIONS

Benefits will not be provided under this rider for:

1. Except where otherwise provided, Prescription Drugs not included on the Formulary.

2. Any devices, appliances, supplies, and equipment except as otherwise provided in Section B, above.

3. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.

4. Prescription Drugs for cosmetic use.

5. Prescription Drugs administered by a physician or dispensed in a physician's office.

6. Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst BlueChoice.

7. Except for items included on the Preventive Drug List, Over-the-Counter medications or supplies lawfully obtained without a prescription such as those that are available in the identical formulation, dosage, form, or strength of a Prescription Drug.

8. Vitamins, except CareFirst BlueChoice will provide a benefit for Prescription Drug:
   a. Prenatal vitamins.
   b. Fluoride and fluoride containing vitamins.
   c. Single entity vitamins, such as Rocaltrol and DHT.
   d. Vitamins included on the Preventive Drug List.

9. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage.

10. Any portion of a Prescription Drug that exceeds:
    a. a thirty-four (34) day supply for Prescription Drugs; or,
    b. a ninety (90) day supply for Maintenance Drugs unless authorized by CareFirst BlueChoice.

12. Prescription Drugs that are 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 a patient in the health care facility.

13. Prescription Drugs for weight loss.

14. Biologicals and allergy extracts.

15. Blood and blood products. (May be covered under the medical benefits in the Evidence of Coverage to which this rider is attached.)

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

CareFirst BlueChoice, Inc.

Chester E. Burrell
President and Chief Executive Officer

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An independent licensee of the Blue Cross and Blue Shield Association

VISION CARE RIDER

This rider contains certain terms that have a specific meaning as to Vision Care benefits. These terms are capitalized and are defined in Section A. below, or in the Contract or Agreement ("evidence of coverage") to which it is attached.

This rider is issued by CareFirst BlueChoice 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.

This rider contains specific exclusions and limitations applicable to Vision Care benefits that are in addition to the exclusions contained in the evidence of coverage to which this rider is attached.

Members are required, in all instances, to receive, Vision Care from a Contracting Provider.

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A. GENERAL PROVISIONS

1. Notwithstanding any provision in the evidence of coverage, benefits for routine Vision Care are limited to the services listed in this rider. Benefits under this rider are administered by CareFirst BlueChoice's Vision Care Designee.

2. To receive benefits under this rider, the Member is required in to receive Vision Care from a Contracting Provider.

3. The Member pays any copayment for a particular service. In addition, the Member will be responsible for services, supplies or care which are not covered. Services, supplies or care provided by a Non-Contracting Provider, supplies or care that are not listed as Vision Care benefits or are listed as an exclusion are not covered services under this rider.

4. Timely Filing.

   All claims submitted to the Vision Care Designee must be submitted within 12 months after the date the covered service is received. The Vision Care Designee will only consider claims beyond the 12-month filing period if the Member became legally incapacitated prior to the end of the filing period.

B. DEFINITIONS. In addition to the definitions contained in the evidence of coverage to which this rider is attached, the underlined terms, below, when capitalized, have the following meanings:

Allowed Benefit means:

For a Contracting Provider, the Allowed Benefit for a covered service is the lesser of:

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

2. The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date that the service is rendered.

The benefit payment is made directly to a Contracting Provider. When a Member receives a vision examination from a Contracting Provider, the benefit payment is accepted as payment in full, except for any applicable copayment. The Contracting Provider may bill the Member directly for such amounts.

Benefit Period means the period of time during which covered Vision Care benefits are eligible for payment. The Benefit Period is on a contract year basis.

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

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

Vision Care means those services for which benefits are provided under this rider.

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

C. WHAT IS COVERED

1. Vision Examination

   a. One vision examination per Benefit Period. A vision examination may include, but is not limited to:

      i. Case history;
      ii. External examination of the eye and adnexa;
      iii. Ophthalmoscopic examination;
      iv. Determination of refractive status;
      v. Binocular balance testing;
      vi. Tonometry test for glaucoma;
      vii. Gross visual field testing;
      viii. Color vision testing;
      ix. Summary finding; and,
      x. Recommendation, including prescription of corrective lenses.

D. HOW IT IS COVERED

When the Member receives a vision examination from a Contracting Provider, the benefit payment is accepted as payment in full, except for any applicable copayment.

E. SCHEDULE OF BENEFITS

SERVICE	VISION CARE DESIGNEE PAYMENT	MEMBER PAYS
Vision Examination	100% of the Allowed Benefit after a Member copayment of $10 when Member receives covered services from a Contracting Provider.	$10

F. EXCLUSIONS

The following services are excluded from coverage:

1. Diagnostic services, except as listed in WHAT IS COVERED.
2. Medical care or surgery. Covered services related to medical conditions of the eye are covered under the evidence of coverage to which this rider is attached.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the evidence of coverage or a rider or endorsement purchased by your Group and attached to the evidence of coverage to which this rider is attached.
4. Services or supplies not specifically approved by the Vision Care Designee where required in WHAT IS COVERED.
5. Orthoptics, vision training and low vision aids.
6. Glasses, sunglasses and contact lenses.
7. Vision Care services for cosmetic use.
8. Services obtained from Non-Contracting Providers.

This rider is issued to be attached to the evidence of coverage.

CareFirst BlueChoice, Inc.

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GROUP INCENTIVE PROGRAM RIDER

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

This rider adds an incentive program to the Evidence of Coverage that rewards Members for: 1) selecting and visiting specific health care providers to manage the Member's care; 2) completing a Health Assessment that the Member and Member's health care provider may use to initiate healthy behavior; and 3) permitting the receipt of wellness-related electronic notices and documents. This rider also adds an outcomes-based incentive that rewards Members for achieving or maintaining certain goals related to health status.

Members receive incentives in the form of a credit to a medical expense debit card.

TABLE OF CONTENTS

A. DEFINITIONS:

In addition to the definitions contained in the Evidence of Coverage to which this rider is attached, the underlined terms below, when capitalized, have the following meanings:

Annual Incentive means the amount of the reward provided to Eligible Members for satisfaction of the incentive requirements set forth in Section B of this rider.

Health Assessment means a (1) questionnaire that asks about the Member's age, habits, recent test results and medical history and (2) diagnostic screenings to identify potential health risks. Based on the answers and information provided, the Health Assessment will explain risk factors and suggest changes the Member can make to improve and maintain his or her health.

PCMH Plus+ Provider means a CareFirst BlueChoice provider who contracted to be a PCMH Plus+ Provider. Members receive an increased Annual Incentive for using a PCMH Plus+ Provider when completing the incentive activities and requirements.

PCMH Primary Care Provider (PCMH PCP) means a Primary Care Provider that participates in the CareFirst BlueChoice Patient-Centered Medical Home Program.

B. INCENTIVE ACTIVITIES AND REQUIREMENTS:

Members who successfully complete each of the following requirements ("Eligible Members") will be provided an Annual Incentive in the form of a medical expense debit card, which can be used to pay any Copayments, Coinsurance, or Deductibles. A Dependent Child is not eligible for any incentive amounts under this rider.

1. Select a PCMH PCP or PCMH Plus+ Provider

A Member must select a PCMH PCP or PCMH Plus+ Provider within 120 days of enrollment or renewal. Members earn a greater incentive for selecting a PCMH Plus+ Provider.

2. Complete the Diagnostic Screening.

A Member must complete the Health Assessment diagnostic screening within 120 days of enrollment or renewal.

3. Complete the Health Assessment Questionnaire

A Member must complete, consent to release, and share with his or her selected PCMH PCP, or PCMH Plus+ Provider, the Health Assessment questionnaire within 120 days of enrollment or renewal.

4. Consent to Receipt of Wellness-Related Communications

A Member must provide consent to receive communications related to healthy lifestyles, well-being, wellness, and disease management information and activities within 120 days of enrollment or renewal. These communications will be provided by electronic means.

C. WELLNESS INCENTIVE BASED ON MEMBER OUTCOMES

These incentives are awarded to Eligible Members who achieve or maintain certain goals related to their health status.

An Eligible Member may be rewarded for achieving or obtaining certain health factors within certain ranges as reported through the Member's diagnostic screening. An Eligible Member who demonstrates compliance with the following ranges within 120 days of enrollment or renewal earns a credit to the medical expense debit card:

Health Factor	Target Profile
1. Body Mass Index	From 19 to less than 30 (age 18 and older) From 5th to 85th percentile (until age 18)
2. Blood Pressure	Less than 140/90 (until age 59) Less than 150/90 (age 60 and older)
3. Blood Glucose	Less than 126 (fasting) Less than 200 (non-fasting)
4. Tobacco	Non User
5. Influenza immunization	Annual

Upon request, or if the Eligible Member does not meet the targets stated in the chart, CareFirst BlueChoice will provide a reasonable alternative standard to, or waiver of, the targets listed in the chart. The Eligible Member's PCMH PCP or PCMH Plus+ Provider shall develop the reasonable alternative standard. The Eligible Member shall then be rescreened at a time determined by the Eligible Member's PCMH PCP or PCMH Plus+ Provider and such provider shall determine whether the Eligible Member has satisfied the reasonable alternative standard.

To request a reasonable alternative standard, the Eligible Member and PCMH PCP or PCMH Plus+ Provider shall complete the CareFirst BlueChoice Health and Wellness form noting that an alternative

standard was set at the Eligible Member's initial screening. The completed form must then be submitted by the Eligible Member, which may be submitted by logging into *My Account* at www.carefirst.com.

At the time determined by the Eligible Member's PCMH PCP or PCMH Plus+ Provider, the Eligible Member shall be rescreened and a second version of the CareFirst BlueChoice Health and Wellness form shall be completed noting whether the alternative standard was met. The completed form must be submitted by the Eligible Member, which may be submitted by logging into *My Account* at www.carefirst.com.

If it is not medically advisable for the Eligible Member to be measured on a specific health factor, the PCMH PCP or PCMH Plus+ Provider may waive any or all of the health factors listed above.

Eligible Members are able to qualify for the incentive in this Section once per Benefit Period.

D. INCENTIVE AMOUNTS

1. PCMH PCP. Members who select a PCMH PCP and complete the participation requirements in Section B will receive the Annual Incentive in the form of a medical expense debit card equal to a maximum incentive of $100 per Benefit Period.

   Eligible Members will be issued the Annual Incentive on an individual basis as the credit is earned.

2. PCMH Plus+ Provider. Members who select a PCMH Plus+ Provider and complete the participation requirements in Section B will receive the Annual Incentive in the form of a medical expense debit card equal to a maximum incentive of $200 per Benefit Period Eligible Members will be issued the Annual Incentive on an individual basis as the credit is earned.

3. Wellness Incentives Based on Member Outcomes. Eligible Members who satisfy the requirements stated in Section C will receive the wellness incentive in the form of a medical expense debit card equal to a maximum incentive of $200 per Benefit Period if the Member selected a PCMH PCP and $400 if the Member selected a PCMH Plus Provider.

   Eligible Members will be issued the wellness incentive on an individual basis as the incentive is earned.

4. Maximum Annual Incentive. The total Maximum Annual Incentive may not exceed $1,200 per family for completion of all participation and outcomes-based incentives, including a $400 maximum for participation-only incentives and a $800 maximum for outcomes-only incentives. If the award of the Annual Incentive to an Eligible Member exceeds the Maximum Annual Incentive allowed for a family, the Annual Incentive awarded to the Eligible Member will be reduced to comply with the Maximum Annual Incentive.

E. CONDITIONS AND LIMITATIONS

1. Members are eligible to qualify for each incentive once per Benefit Period.

2. Providers may join or leave the PCMH program or be designated a PCMH Plus+ Provider at any time. To earn the Annual Incentive, a Member must select a Primary Care Provider who is a PCMH PCP or PCMH Plus+ Provider at the time the selection is made.

3. Only one medical expense debit card credited with any earned incentives will be issued per family. The medical expense debit card may be used by any Member in the family.

4. Once the Annual Incentive is awarded in a Benefit Period, it will not be withdrawn nor any amounts recouped during the Benefit Period.

5. The Wellness Incentive Based on Member Outcomes in Section C is only available to Members that first satisfy the Incentive Activities and Requirements in Section B.

6. Members agree to comply with any requirements concerning the use of the medical expense debit card.

7. If the Member's Evidence of Coverage is compatible with a federally-qualified Health Savings Account the medical expense debit card:

   a) cannot be used to pay for qualified medical expenses or other cost-sharing responsibilities unless (i) the Member first satisfies his/her minimum deductible as established by the Internal Revenue Service or (ii) the Member provides a signed agreement stating that he/she has not funded and agrees not to fund an HSA account during the Benefit Period; and

   b) can be used to pay for eligible dental and vision expenses that are part of the Member's benefit plan.

8. Members may satisfy the Health Assessment requirement in Section B.2 by receiving the health and wellness evaluation, including diagnostic screenings or other steps to measure and evaluate the Member's health or risk factors, through any employer-directed process approved by CareFirst BlueChoice, so long as the Member consents to share the results, and shares the results, with the Member's PCMH PCP within the designated timeframes to qualify for the wellness incentive.

9. If the coverage allows for out-of-area benefits that extend beyond Emergency Services, Urgent Care, and follow-up care after emergency surgery, Members residing outside of CareFirst BlueChoice's service area will earn the participation incentive by selecting a participating provider in a PCP-like specialty (family practice, general practice, internist, geriatrics, pediatrics) in the Blue Cross and Blue Shield Plan where the Member resides and completing the activities identified in Section B. Members residing outside of CareFirst BlueChoice's service area are eligible for the outcome incentives, but are not eligible for the greater incentive provided for selecting a PCMH Plus+ Provider.

10. Only a Subscriber and Subscriber's Dependent Spouse are eligible for incentives under this rider. Dependent Children are not eligible for any incentives under this rider.

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

CareFirst BlueChoice, Inc.

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ATTACHMENT D

ELIGIBILITY SCHEDULE

Contract Renewal Date	February 01, 2019
Eligibility	
Subscriber	A Subscriber must reside or work in the Service Area. A full-time wage-earning employee; who works at least 30 hours per week on a regular (not seasonal or temporary) basis. NOTE: A wage earning employee is a person who is compensated 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. An eligible employee or eligible participant of the Group, who is subject to the provisions of the Family and Medical Leave Act of 1993, as stated therein.
Spouse	Coverage for a spouse is available.
Dependent children	Coverage for Dependent children is available.
Type of Coverage	Individual, Individual and Child(ren), Individual and Adult, Family
Limiting Age for Dependent Children (other than incapacitated children)	Up to age 26
Limiting Age for Student Dependents	Up to age 26

Effective Dates	
Open Enrollment Effective Date	February 01, 2018
Existing Subscriber Effective Date	An existing Subscriber is eligible for coverage on the Effective Date of the Group
Existing Dependent Effective Date	An existing Dependent is eligible for coverage on the Effective Date of the Group
New Subscriber Eligibility Date	A new employee or other new participant of the Group is eligible for coverage effective on the first day of the month after the Subscriber satisfies the Group's Waiting Period of 30 days after employment or eligibility, whichever is later. If a Section 125 Plan, within 31 days after any event which, in the judgment of the Plan Administrator qualifies as a status change or other allowable change under Section 125 of the Internal Revenue Code (family status changes) a new Subscriber is eligible for coverage effective the first of the month following acceptance of the enrollment form by CareFirst BlueChoice.
Newly eligible Dependent child (newborn, newly adopted child, Dependent Child for whom guardianship has been established by court or testamentary appointment, newly eligible grandchild or child subject to a MCSO/QMSO)	Newly born Dependent child: the date of birth. 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. Testamentary or court appointed guardianship of a Dependent child: the date of appointment. 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: Medical Child Support Order: the date specified in the Medical Child Support Order. Qualified Medical Support Order: the date specified in the Medical Child Support Order. 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.
New Dependent (other than newborn, newly adopted child, Dependent Child for whom guardianship has been established by court or testamentary appointment newly eligible grandchild, or child subject to a MCSO/QMSO)	The date first eligible.

Special Enrollment Periods	
Subscribers who are eligible for special enrollment (except for those who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility)	The employee must notify the Group, and the Group must notify CareFirst BlueChoice no later than 31 days after (1) 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; (2) the termination of employer contributions toward that other coverage; or (3) a person becomes a newly-eligible Dependent of the Subscriber through marriage, or becomes a newly-eligible Dependent Child of the Subscriber. 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 BlueChoice will allow the employee a period of at least 31 days after a claim is denied due to the operation of a lifetime limit on all benefits. Coverage for a new Subscriber eligible for special enrollment is effective on the first of the month following acceptance of the enrollment form by CareFirst BlueChoice or, when a person becomes a newly-eligible Dependent through marriage or a newly-eligible Dependent Child of the Subscriber, the date specified for Dependents who are eligible for special enrollment below.
Dependents who are eligible for special enrollment (except for those who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility)	In the case of a Dependent who loses coverage and is eligible for special enrollment, the employee must notify the Group, and the Group must notify CareFirst BlueChoice no later than 31 days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst BlueChoice will allow the employee a period of at least 31 days after a claim is denied due to the operation of a lifetime limit on all benefits. Coverage for a Dependent who loses coverage and is eligible for special enrollment is effective on the first of the month following acceptance of the enrollment form by CareFirst BlueChoice. In the case of a newly-eligible Dependent (newly-eligible spouse or newly-eligible Dependent Child), the employee must notify the Group, and the Group must notify CareFirst BlueChoice during the 31-day special enrollment period beginning on the date of the marriage; the date of birth; the date of Adoption or placement for Adoption; in the case of an eligible grandchild, the date upon which the grandchild became a Dependent of the Subscriber or the Subscriber's spouse; in the case of a child that is the subject of a MCSO or QMSO, the date specified in the MCSO or QMSO; or, in the case of a minor for whom guardianship is granted by court or testamentary appointment, the date of appointment.

	Coverage for a newly-eligible Dependent who is eligible for special enrollment is effective as of the effective dates provided above for a Newly eligible Dependent child (newborn, newly adopted child, Dependent Child for whom guardianship has been established by court or testamentary appointment, newly eligible grandchild or child subject to a MCSO/QMSO) or a New Dependent (other than newborn, newly adopted child, Dependent Child for whom guardianship has been established by court or testamentary appointment newly eligible grandchild, or child subject to a MCSO/QMSO).
Subscribers and Dependents who are eligible for special enrollment due to Medicaid and CHIP termination or eligibility	The employee must notify the Group, and the Group must notify CareFirst no later than 60 days after the date the employee or Dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act. The employee must notify the Group, and the Group must notify CareFirst, no later than 60 days after the date the employee or Dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan). Coverage for a new Subscriber and/or his/her Dependents is effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or, the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.

Termination of Coverage	
Subscribers no longer eligible	Coverage ends on the last day of the month in which employment or eligibility terminates.
Dependent Child	End of the month following their 26th birthday
Student Dependents	End of the month following their 26th birthday
Dependent no longer eligible (includes marriage of child or divorce of spouse)	A Dependent will remain covered until the end of the month in which the Dependent no longer meets the eligibility requirements stated in the Evidence of Coverage.
Death of Subscriber	Coverage ends on the last day of the month after the Subscriber's death

CareFirst BlueChoice, Inc.

Chester E. Burrell
President and Chief Executive Officer

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