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

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.

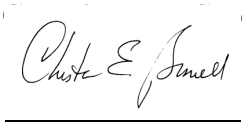
Members have no benefits after a plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of the plan termination and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state, or local law.

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

Group Name: 51+ BlueChoice HMO Option 13

Group Number:

Effective Date: March 1, 2014



Chester E. Burrell
Chief Executive Officer and President

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 may be paid to the Member or to the Non-Contracting Physician or Non-Contracting Provider at the discretion of CareFirst BlueChoice. When benefits are paid to the Member, 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 Calendar 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 of the five 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 setting.

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

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.
The fact that a health care provider may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Contract.

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 Dependent means a grandchild, niece or nephew for whom the Subscriber provides primary care including food, shelter, and clothing on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.

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 to whom a Member can be referred by a Primary Care Physician

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 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. A child placed with the Subscriber or the Subscriber's covered Spouse for legal Adoption;

3. 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;

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;

5. A grandchild, niece or nephew, who meets the requirements for coverage as the Subscriber's Primary Care Dependent as stated below:

   a. The child must be the Subscriber's grandchild, niece, or nephew;

   b. The child is under the Subscriber's Primary Care. Primary Care means that the Subscriber provides food, clothing and shelter for the child on a regular and continuous basis during the time that the District of Columbia public schools are in regular session; and,

   c. If the child's legal guardian is someone other than the Subscriber, the child's legal guardian is not covered under any other health insurance policy.

   The Subscriber must provide CareFirst BlueChoice with proof upon application, that the child meets the requirements for coverage as a Primary Care Dependent, including proof of the child's relationship and primary dependency on the Subscriber and certification that the child's legal guardian does not have other coverage. CareFirst BlueChoice reserves the right to verify whether the child is and continues to qualify as a Primary Care Dependent.

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, 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.

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

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

4. for a minor for whom guardianship of at least 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.

E. Special Enrollment Regarding Medicaid and CHIP Termination of Eligibility. CareFirst BlueChoice will permit an individual 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 are met:

1. The individual 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 individual or dependent becomes eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State

child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

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 District of Columbia Continuation of Health Coverage ("DCCHC"). This provision applies to Subscribers enrolled in an employer-maintained health benefit plan for less than 20 employees.

1. The Subscriber and his/her Dependents covered under this Evidence of Coverage at the time eligibility for group coverage under this Evidence of Coverage is terminated have the right to continue coverage under the Group's contract for a period of three (3) months, unless:

   a. The Subscriber's employment was terminated for gross misconduct;

   b. The Member is eligible for any extension of coverage required under COBRA; or

   c. The Member fails to complete timely election and payment as provided below.

2. Duties of the Group.

   a. The Group shall furnish Subscribers whose coverage terminates written notification of the Subscriber's eligibility to continue coverage under DCCHC. Such notice shall be furnished no later than fifteen (15) days of the date coverage under this Evidence of Coverage would otherwise terminate. Failure by the Group to furnish the required notification shall not extend the right to continue coverage beyond the three-month period.

   b. The Group shall forward to CareFirst BlueChoice the names of Members who

apply for DCCHC continuation of coverage within fifteen (15) days from the date of application.

3. Duties of the Subscriber.

   a. Individuals who elect coverage under this Section shall bear the cost of the continued coverage for himself/herself and his/her Dependents and such cost shall not exceed one hundred two percent (102%) of the Group's rate.

   b. An individual who elects to continue coverage shall tender to the Group the amount described above within forty-five (45) days from the date coverage under this Agreement would otherwise terminate.

4. Termination of Continued Coverage. Coverage under this provision shall continue without interruption for the continued eligibility period and shall not terminate unless:

   a. The Member establishes residence outside CareFirst BlueChoice's Service Area;

   b. The Member fails to make timely payment of the required cost of coverage;

   c. The Member violates a material condition of this Evidence of Coverage;

   d. The Member becomes covered under another group health benefits plan that does not contain any exclusion or limitation with respect to any preexisting condition that affects the Member;

   e. The Member becomes entitled to Medicare; or

   f. The Group no longer offers group coverage to any employee.

5. The Member shall be entitled to a Conversion Contract in accordance with Section 5 upon termination of his/her continued eligibility period as defined in this section.

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"); SUBROGATION

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 reduced when, under the order of determination rules, this CareFirst BlueChoice Plan determines its benefits before another Plan;

   b. may be reduced when, under the order of determination rules, another Plan determines its benefits first. The reduction 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 stated 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, including those of nonprofit health service Plan, and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage under a governmental Plan, or coverage required or provided by law. This does not include a State Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

The term Plan does not include:

1. An individually underwritten and issued, guaranteed renewable, specified disease policy;

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

3. Coverage regulated by a motor vehicle reparation law;

4. The first 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 reduced because of the other Plan's benefits.

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

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

C. Order of 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 stated 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 reduced under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

2. Reduction in this CareFirst BlueChoice Plan's Benefits

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

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

E. Right to Receive and Release Needed Information

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

F. Facility of Payment

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

G. Right of Recovery

If the amount of the payments made by this CareFirst BlueChoice Plan is more 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.

6.3 Subrogation

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

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

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

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

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

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

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

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

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

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

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

SECTION 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 thirty (30) 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 District of Columbia by the Department of Insurance and Securities Regulation pursuant to Title 31 of the District of Columbia Code and the District of Columbia Department of Health pursuant to Reorganization Plan No. 4 of 1996.

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

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, 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.

An authorized representative may act on behalf of the Member in pursuing a benefit claim or appeal of an Adverse Benefit Determination. CareFirst BlueChoice may require reasonable proof to determine whether an individual has been properly authorized to act on behalf of a Member. In the case of a claim involving Urgent/Emergent Care, a Health Care Provider with knowledge of a Member's medical condition is permitted to act as the authorized representative.

TABLE OF CONTENTS

A. DEFINITIONS

Adverse Benefit 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 Benefit 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 a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Pre-Service Claim means 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 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 a Pre-Service or Concurrent Care claim for medical care or 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 medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the 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 medical 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. 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 medical exigencies, the earlier of:

   a. 24 hours after CareFirst BlueChoice's receipt of the necessary information to make the benefit determination, or

   b. 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 medical 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 CareFirst BlueChoice procedures for filing a Pre-Service Claim, the Member or authorized 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 medical 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 the CareFirst BlueChoice's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time 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 such course of treatment (other than by a change in the plan'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 medical 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 Benefit Determination is required to be made shall begin at the time a claim is filed in accordance with CareFirst BlueChoice procedures. The 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.

C. INTERNAL GRIEVANCE PROCEDURE

1. A grievance must be filed within 180 days from the date of receipt of the written notice of any Adverse Benefit 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 a grievance. All grievances filed should be in writing, except grievances 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. The grievance 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.

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 benefit determination;

   b. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; 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, the plan provisions have been applied consistently with respect to similarly situated members.

6. A grievance and any applicable documentation should be sent to the correspondence address stated on the reverse of the Member identification card.

7. Timing of CareFirst BlueChoice responses. The time limits for responding to a grievance 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 a grievance decision and written notification will be sent.

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

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

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 a grievance 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. FAIR AND FULL REVIEW

CareFirst BlueChoice will provide a review that:

1. 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;

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

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

4. 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 Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and,

5. The Health Care Provider engaged for purposes of a consultation is an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination, nor the subordinate of any such individual.

E. 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 for Benefits, 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 for Benefits. If a Member chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the Claim for Benefits, Grievance, or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

F. EXTERNAL APPEAL PROCEDURE

A Member who is dissatisfied with a decision rendered in a final internal grievance process shall have the opportunity to pursue an appeal before an external independent review organization if filed within 4 months of the final grievance decision.

If a Member is dissatisfied with the resolution reached through CareFirst BlueChoice BlueChoice's internal grievance system regarding medical necessity, the Member may contact the Director, Office of Health Care Ombudsman and Bill of Rights, at the following:

Director
Office of Health Care Ombudsman and Bill of Rights
One Judiciary Square, 9th Floor
441 4th Street, NW
Washington, DC 20001
((877) 685-6391 or fax (202) 478-1397)

If a Member is dissatisfied with the resolution reached through CareFirst BlueChoice BlueChoice's internal grievance system regarding all other grievances, the Member may contact the Commissioner at the following:

District of Columbia Department of Insurance, Securities and Banking
Consumer Services Division
810 First Street, NE
Suite 701
Washington, DC 20002
((202) 727-8000 or fax (202) 535-1197or (202) 354-1085)

CareFirst BlueChoice, Inc.

Chester E. Burrell
Chief Executive Officer and President

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

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ATTACHMENT B
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
Chief Executive Officer and President

SECTION 1
OUTPATIENT AND OFFICE SERVICES

WHERE	CAREFIRST BLUECHOICE PROVIDES	MEMBER PAYS
In Contracting Physicians' offices or in other Contracting Provider facilities when provided by or upon written referral from a Primary Care 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.

MOST CARE MUST BE PROVIDED BY, OR UPON WRITTEN REFERRAL OF, THE MEMBER'S PRIMARY CARE PHYSICIAN. (See the important "Referral" information included in Section 9.)

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, annual digital rectal exam 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.

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 and in accordance with CareFirst BlueChoice Preventive Guidelines.

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. Except for infertility services, a female Member can self-refer to a Contracting Provider obstetrician-gynecologist. Benefits include health care services incidental to and rendered during an annual visit. The obstetrician-gynecologist may need to contact the Member's Primary Care Physician to arrange referrals for additional services from another specialist. Consultation with the Primary Care Physician may be by telephone or electronically.

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) 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. Habilitative Services for Children. Habilitative Services are services, including Occupational Therapy, Physical Therapy and Speech Therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. Benefits are not covered for Habilitative Services delivered through early intervention or school services.

Prior authorization is required for Habilitative Services or for any other service provided by the same provider on the same day as these services.

Benefits for Habilitative Services will be provided for children under the age of 21.

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. Routine hearing screening consisting of one of the following:

a. Auditory brain stem response;

b. Otoacustic emissions; or

c. Other appropriate, nationally recognized, objective physiological screening test.

Q. Medical foods and low protein modified food products for the therapeutic treatment, under the direction of a Contracting Physician, of inherited metabolic diseases. A low protein modified food product means a food product that is specially formulated to have less than 1 gram of protein per serving (excluding a natural food that is naturally low in protein).

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. Spinal Manipulation services are limited to Members who are twelve (12) years of age or older.

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 as determined by CareFirst BlueChoice.

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 Infertility Services.

A. Benefits are provided for Medically Necessary, non-Experimental/Investigational Artificial Insemination (AI) procedures and associated services (including intrauterine insemination).

B. Conditions for Coverage:

1. Prior authorization for the treatment must be obtained from CareFirst BlueChoice.

2. Benefits are limited to six attempts per live birth.

3. The Member is responsible for the Copayment or Coinsurance for AI stated in the Schedule of Benefits.

4. Coverage is subject to the exclusions listed in the Exclusions and Limitations Section at the end of this Description of Covered Services.

1.7 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.

1.8 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.

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.

1.9 Dental Services.

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) when the Member requests treatment within 60 days of the accident.

1.10 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, when the Member requests oral surgical services or dental services for sound natural teeth and supporting structures or the need for oral surgical services or dental services for sound natural teeth and supporting structures is identified in the Member's medical records within 60 days of the accident.

C. Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness.

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.

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

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.

1.12 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.

1.13 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 if referred by a Primary Care 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 to whom the Member was referred. 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, 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 for the treatment of breast cancer.

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 when referred by a Primary Care 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 to whom the Member was referred.

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;

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

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 when referred by a Primary Care 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 to whom the Member was referred by a Primary Care 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 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 PROGRAM

6.1 Definitions.

A. 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. Medically or Psychologically Necessary means essential for the treatment of drug abuse, alcohol abuse, or mental illness as determined by a physician, psychologist or social worker and authorized or approved by CareFirst BlueChoice's Mental Health and Substance Abuse Management Program.

C. Qualified Treatment Facility means a non-Hospital residential facility certified by the District of Columbia or by any jurisdiction in which it is located, as a qualified non-Hospital provider of treatment for drug abuse, alcohol abuse, mental illness, or any combination of these, in a residential setting. A non-Hospital residential facility includes any facility operated by the District of Columbia, any state or territory or the federal government to provide these services in a residential setting. It is not a facility licensed as a general or special Hospital. A non-Hospital residential facility also must meet or exceed guidelines established for such a facility by CareFirst BlueChoice.

D. 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 for Medically or Psychologically Necessary 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 or referrals from a Primary Care Physician for methadone maintenance treatment.

C. Coverage of Medically or Psychologically Necessary services for 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 Medically or Psychologically Necessary 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 a Hospital or non-Hospital residential 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.

F. Benefits are available for the costs of a voluntary HIV test, performed during a Member's visit to a hospital emergency room, regardless of the reason for the hospital emergency room visit.

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 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 any 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 any 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 any 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
REFERRALS

9.1 Referral Requirements.

A. Benefits for services rendered by Contracting Physicians other than the Primary Care Physician are only provided when prior written referral by a Primary Care Physician is obtained for the specified Covered Service.

B. The exceptions to the Primary Care Physician referral requirement are listed below in Section 9.2.

9.2 Exceptions to Requirement for Primary Care Physician Referral. A Member may self-refer to Contracting Providers for:

A. Covered gynecological and obstetric services rendered by a Contracting Provider obstetrician/gynecologist except for infertility services.

B. Covered Services rendered at Contracting Provider radiologist offices when ordered by a Contracting Provider or Non-Contracting Provider.

C. Covered Services rendered by a Contracting Provider laboratory when ordered by a Contracting Provider or a Non-Contracting Provider.

D. Emergency and Urgent Care services as described in Section 7.

E. Covered Services that are directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an Oncologist, chemotherapy, and radiation therapy by Contracting Providers. Benefits are subject to review and approval under utilization management requirements established by CareFirst BlueChoice. Contracting Providers will handle utilization management procedures on behalf of the Member.

Note: CareFirst BlueChoice reserves the right to make changes to the categories of providers or services that do not require a Primary Care Provider referral. Notice of such changes will be provided to the Member.

9.3 Standing or Condition Management Referral to a Specialist.

A. Definitions.

1. A Condition Management Referral is a referral that allows a Contracting Specialist to act as a Primary Care Physician:

a. Solely for the condition for which the Member was referred; and

b. Only for the authorized treatment period.

The Contracting Physician Specialist shall be permitted to provide and coordinate the primary and specialty care for the Member's condition and includes authorizing such referrals, procedures, tests, and other medical services as the Member's Primary Care Physician would otherwise be permitted to provide or authorize.

2. A Standing Referral is a referral to a Contracting Specialist that does not have a specified treatment period. The referral is subject to periodic review by the Primary Care Physician and CareFirst BlueChoice to determine whether the Standing Referral continues to be Medically Necessary as authorized or approved by CareFirst BlueChoice.

3 Specialist as used in this section means a physician who is:

a. Certified or eligible for certification by the appropriate specialty board; and

b. Trained in practice in a specified field of medicine.

B. Condition Management Referral or Standing Referral to a Specialist.

1. A Member may request a Condition Management Referral or a Standing Referral from the Primary Care Physician to a Specialist for a condition that:

a. Is life threatening, degenerative, or disabling; or

b. Requires a Specialist over a prolonged period of time.

2. Upon request for a referral, the Primary Care Physician will contact CareFirst BlueChoice to obtain authorization.

C. Standing Referral for Cancer Patients.

1. A Member who has been diagnosed with cancer may request a Standing Referral from their Primary Care Physician to a:

a. Contracting Physician who is a board-certified physician in pain management; or

b. Contracting Physician who is an oncologist.

2. A Standing Referral does not authorize the Contracting Physician to assume the responsibilities for care other than cancer care and pain management. The referral is subject to periodic review by the Primary Care Physician and CareFirst BlueChoice.

9.4 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.

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

9.6 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 (except artificial insemination and intrauterine insemination), including 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; use of passive or patient-activated exercise equipment.

P. Treatment for obesity, including the 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. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy, excluding no fault insurance.

GG. 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).

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

II. Services required solely for employment, insurance, foreign travel, school, camp

admissions or participation in sports activities.

10.2 Infertility Services. Coverage for Artificial Insemination (and intrauterine insemination) does not include the following:

A. Any costs associated with freezing, storage or thawing of sperm for future attempts or other use.

B. Any charges associated with donor sperm.

C. Infertility services that include the use of any surrogate or gestational carrier service.

D. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures, with or without reversal.

E. All self-administered fertility drugs.

10.3 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.

10.4 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.

10.5 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.

10.6 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.

10.7 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.

10.8 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.

10.9 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 the Evidence of Coverage.

10.10 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.

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

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ATTACHMENT C
SCHEDULE OF BENEFITS

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

Benefit Period: Benefit Period is a [calendar] year.

Service	Limit on Benefits	Member Payment
SECTION 1 – OUTPATIENT AND OFFICE SERVICES		
Office Visits	[Office visits to CareFirst BlueChoice Specialists require written referral from a Primary Care Physician (PCP), except as otherwise provided in the Description of Covered Services.]	$30 per visit (PCP) $40 per visit (Specialist)
Laboratory Tests and X-rays		No Copayment or Coinsurance
Other Diagnostic Testing (except as otherwise provided)		$30 per visit (PCP) $40 per visit (Specialist)
Preventive Care		
Prostate Cancer Screening	In accordance with the most current American Cancer Society guidelines	Subject to office visit Copayment.
Colorectal Cancer Screening	In accordance with the most current American Cancer Society guidelines	Subject to office visit Copayment.

Service	Limit on Benefits	Member Payment
Routine Pap Smear	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.	Subject to office visit Copayment.
Mammography		No Copayment or Coinsurance.
Well Child Care		$30 per visit (PCP)
Adult Preventive Care		$30 per visit (PCP) $40 per visit (Specialist)
Treatment Services		
Allergy Treatment	Number of visits not limited	$30 per visit (PCP) $40 per visit (Specialist)
Eye Care (Medical Treatment)		$30 per visit (PCP) $40 per visit (Specialist)
Rehabilitation Services (includes Physical Therapy, Occupational Therapy and Speech Therapy)	Prior authorization is not required for Rehabilitation Services or for any other service provided by the same provider on the same day as these services. Limited to 30 visits per condition per Benefit Period.	$40 per visit
Chemotherapy		$40 per visit
Habilitative Services	Limited to Members under the age of 21.	$40 per visit
Spinal Manipulation Services	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. Limited to 20 visits per Benefit Period Benefits are limited to Members who are twelve (12) years of age or older.	$40 per visit
Limited Service Immediate Care		$40 per visit
Cardiac Rehabilitation	Limited to 90 visits per Benefit Period. Prior authorization is not required.	$40 per visit

Service	Limit on Benefits	Member Payment
Pulmonary Rehabilitation	Limited to one (1) pulmonary rehabilitation program per lifetime. Prior authorization is not required.	$40 per visit
Infertility Services		
Artificial Insemination	Limited to 6 attempts per live birth.	$40 per visit
Maternity Care		
Maternity Care	The Member maximum payment per pregnancy for PCP or Specialist care applies only to care performed by the Member's attending obstetrician(s). The Member maximum payment does not apply to any other Covered Services provided by a PCP or Specialist who is not the attending obstetrician.	$300 per pregnancy or $30 per PCP office visit up to Member maximum payment of $300 per pregnancy if no live birth $400 per pregnancy or $40 per Specialist office visit up to Member maximum payment of $400 per pregnancy if no live birth.
Hair Prosthesis		
Hair Prosthesis	Limited to a maximum CareFirst BlueChoice payment of $350 for one hair prosthesis per Benefit Period.	No Copayment or Coinsurance
Outpatient Facility and Professional Services		
Outpatient Hospital or Ambulatory Care Facility Services		No Copayment or Coinsurance
Outpatient Medical and Surgical Professional Services Provided at an Outpatient Hospital or Ambulatory Care Facility		$30 per visit (PCP) $40 per visit (Specialist)
SECTION 2 – INPATIENT HOSPITAL SERVICES		
Inpatient Facility (medical or surgical condition, including maternity and rehabilitation)	No prior authorization required for routine maternity admissions. Hospitalization solely for Rehabilitation limited to 90 days per Benefit Period.	$300 per admission

Service	Limit on Benefits	Member Payment
Inpatient Professional Services		No Copayment or Coinsurance
SECTION 3 – SKILLED NURSING FACILITY SERVICES		
Skilled Nursing Facility Services	Number of covered days not limited	No Copayment or Coinsurance
SECTION 4 – HOME HEALTH SERVICES		
Home Health Services	Number of visits not limited	No Copayment or Coinsurance
SECTION 5 – HOSPICE CARE SERVICES		
Hospice Care Services – Limited to the Hospice Eligibility Period. See Section 5.3 of the Description of Covered Services.		
Hospice Care	Unlimited visits during Hospice Eligibility Period	No Copayment or Coinsurance
Respite Care	Limited to 3 periods of 48 hours during the Hospice Eligibility Period	No Copayment or Coinsurance
Bereavement Services	Limited to the 90-day period following the patient's death with a maximum of 3 visits.	No Copayment or Coinsurance
SECTION 6 – MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Services		
Mental Health		$40 per visit
Substance Abuse		$40 per visit
Medication Management		$30 per visit (PCP) $40 per visit (Specialist)
Inpatient Services		
Mental Health		
Inpatient Facility Services		$300 per admission

Service	Limit on Benefits	Member Payment
Inpatient Professional Services		No Copayment or Coinsurance
Substance Abuse		
Inpatient Facility Services		$300 per admission
Inpatient Professional Services		No Copayment or Coinsurance
Partial Hospitalization Program		No Copayment or Coinsurance
SECTION 7 – EMERGENCY SERVICES AND URGENT CARE		
Contracting Provider Urgent Care Facility	Limited to Emergency Services or unexpected, urgently required services	$40 per visit
Hospital Emergency Room or Non-Contracting Urgent Care Facility	Limited to Emergency Services or unexpected, urgently required services	$50 per visit, waived if admitted as inpatient
Other Emergency Services or urgently required services provided by a Non-Contracting Physician	Limited to unexpected, urgently required services	$40 per visit
SECTION 8 – MEDICAL DEVICES AND SUPPLIES		
Medical Devices and Supplies	Limited to a maximum CareFirst BlueChoice payment of $7500 per Benefit Period.	25% of the Allowed Benefit

MAXIMUM ANNUAL COPAYMENT AND COINSURANCE	
If the Group offering includes **two** Types of Coverage, the Maximum Annual Copayments and Coinsurance are:	If the Group offering includes **three** Types of Coverage, the Maximum Annual Copayments and Coinsurance are:
Individual $1,300* Family $2,600	Individual $1,300* Individual and Adult or Individual and Child $2,600 Family $2,600
If the Group offering includes **four** Types of Coverage, the Maximum Annual Copayments and Coinsurance are:	If the Group offering includes **five** Types of Coverage, the Maximum Annual Copayments and Coinsurance are:
Individual $1,300* Individual and Child $2,600 Individual and Adult $2,600 Family $2,600	Individual $1,300* Individual and Child $2,600 Individual and Adult $2,600 Individual and Children $2,600 Family $2,600

* If Coverage is complementary to Medicare, the Maximum Annual Copayment and Coinsurance is $1,300.

Except as provided below, total Copayments and Coinsurance paid during a Benefit Period by a Subscriber and, if applicable, his or her Dependents are subject to the Maximum Annual Copayment and Coinsurance established for the Type of Coverage in which the Member is enrolled (e.g., Individual or Family) as set forth in the table above. The Subscriber's Maximum Annual Copayment and Coinsurance applies on a Benefit Period basis even though the Member may have been enrolled for less than a Benefit Period.

If the Subscriber is enrolled under Family coverage, Individual and Children coverage, or, if applicable, Individual and Adult or Individual and Child coverage, the Maximum Annual Copayment and Coinsurance may be met if the individual Copayments and Coinsurance exceed the Maximum Annual Copayment and Coinsurance established for Individual coverage. In addition, if the total Copayments and Coinsurance of all covered family members exceed the Maximum Annual Copayment and Coinsurance for the Type of Coverage in which the Subscriber is enrolled, all covered family members will be deemed to have met the Maximum Annual Copayment and Coinsurance. However, an individual family member cannot contribute more than the Maximum Annual Copayment and Coinsurance for Individual coverage.

CareFirst BlueChoice will notify the Member if the Maximum Annual Copayment and Coinsurance is reached, based on billing and claims information in CareFirst BlueChoice's records. If the Maximum Annual Copayment and Coinsurance is satisfied, the Member will be entitled to a refund of any excess Copayments and Coinsurance paid and, for the remainder of the Benefit Period, will not be required to pay additional Copayments and Coinsurance for services that are subject to the Maximum Annual Copayment and Coinsurance.

The Maximum Annual Copayment and Coinsurance limit does <u>not</u> apply to charges or Copayments and Coinsurance in connection with any of the following:

- Charges for services that are not covered under this Evidence of Coverage or which exceed the maximum number of covered visits/days under the Member's coverage.
- Copayments and Coinsurance required under any riders to this Evidence of Coverage, unless the rider specifically states otherwise.

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840 First Street, NE
Washington, DC 20065
202-479-8000

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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

CareFirst BlueChoice has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever Members obtain Out-of-Area Covered Healthcare Services outside of the CareFirst BlueChoice Service Area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside the CareFirst BlueChoice Service Area, Members will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers" or "contracted providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. CareFirst BlueChoice payment practices in both instances are described below.

CareFirst BlueChoice covers only limited healthcare services received outside of its Service Area. As used in this amendment "Out-of-Area Covered Healthcare Services" means:

1. Emergency Services;
2. Urgent Care;
3. Follow-up care after emergency surgery for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's Primary Care Physician;

obtained outside the geographic area CareFirst BlueChoice serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements unless authorized by your primary care physician ("PCP")**.**

A. BlueCard® Program

Under the BlueCard® Program, when Members obtain Out-of-Area Covered Healthcare Services from a provider within the geographic area served by a Host Blue, CareFirst BlueChoice will remain responsible for fulfilling its contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables Members to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to the Member, so there are no claim forms for the Member to fill out. Members will be responsible for the Member payment amount, as stated in the Evidence of Coverage.

Emergency Care Services: A Member requiring Emergency Services while traveling outside the CareFirst BlueChoice Service Area should go to the nearest emergency or Urgent Care facility.

Whenever a Member accesses Out-of-Area Covered Healthcare Services and the claim is processed through the BlueCard Program, the amount the Member pays for Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price CareFirst BlueChoice uses for a claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, CareFirst BlueChoice would then calculate Member liability for any Out-of-Area Covered Healthcare Services according to applicable law.

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

Member Liability Calculation: When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount the Member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable law. In any case, the Member will only be liable for any Deductible or Copayment for the Out-of-Area Covered Healthcare Services as set forth in the Evidence of Coverage.

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
Chief Executive Officer and President

CareFirst BlueChoice, Inc.
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Washington, DC 20065
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SPECIAL ENROLLMENT PERIODS AMENDMENT

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

The following is added to Section 2.6, Enrollment Opportunities and Effective Dates, C. Special Enrollment Periods, of the Evidence of Coverage.

4. Special Enrollment Regarding Medicaid and CHIP Termination or Eligibility:

   CareFirst BlueChoice will permit an individual 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:

   a. The individual 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 individual or dependent under such a plan is terminated as a result of loss of eligibility for such coverage;

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

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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DEFINITION OF SPOUSE AMENDMENT

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

The definition of Spouse in the Evidence of Coverage is replaced with the following:

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

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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Washington, DC 20065
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DEPENDENT ELIGIBILITY AMENDMENT

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

Sections 2.4 and 2.5 of the Evidence of Coverage are deleted and replaced with the following:

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. If older than the age requirements described in Section 2.5 below, the child may be eligible for coverage if the Subscriber provides proof that: (1) the Dependent child is incapable of self-support or maintenance because of a medical or mental disability; (2) the Dependent child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse for support and maintenance; and (3) the Dependent child had been covered under the Subscriber's or the Subscriber's Spouse's prior health insurance coverage since before the onset of the medical or mental disability.

C. Be unmarried; and

D. Be related to the Subscriber in one of the following ways:

1. The Subscriber's or the Subscriber's Spouse's Dependent child by birth or legal Adoption;

2. A child placed with the Subscriber or the Subscriber's covered Spouse for legal Adoption;

3. 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 Subscriber's Spouse;

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;

5. A grandchild, niece or nephew, who meets the requirements for coverage as the Subscriber's Primary Care Dependent as stated below:

a. The child must be the Subscriber's grandchild, niece, or nephew;

b. The child is under the Subscriber's Primary Care. Primary Care means that the Subscriber provides food, clothing and shelter for the child on a regular and continuous basis during the time that the District of Columbia public schools are in regular session; and,

c. If the child's legal guardian is someone other than the Subscriber, the child's legal guardian is not covered under any other health insurance policy.

The Subscriber must provide CareFirst BlueChoice with proof upon application, that the child meets the requirements for coverage as a Primary Care Dependent, including proof of the child's relationship and primary dependency on the Subscriber and certification that the child's legal guardian does not have other coverage. CareFirst BlueChoice reserves the right to verify whether the child is and continues to qualify as a Primary Care Dependent.

E. 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.

F. A child whose relationship to the Subscriber is not listed above, including, but not limited to, foster children or children whose only relationship is one of legal guardianship (except as provided above) is not eligible to enroll and is 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 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 for Dependent children if the Eligibility Schedule provides a Limiting Age for Student Dependents and if the Dependent children meet the requirements for Student Dependents, as described below. Coverage, if available, 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. CareFirst BlueChoice will provide coverage for an eligible Dependent child who is originally enrolled as a full-time student and becomes unable due to medical or mental disability to continue as a full-time student. Coverage will continue for a period of twelve (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 require verification of the disability from the Dependent child's treating Health Care Provider, a disability services professional employed by the institution that the Dependent child attends, or a Health Care Provider with special expertise in and knowledge of the disability. A Dependent 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.

3. 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.

C. A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if, at the time coverage would otherwise terminate

1. The Dependent child is incapable of self-support or maintenance because of medical or mental disability;

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

3. The disability 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 disability occurred before the Dependent child reached the Student Dependent Limiting Age, specified in the Eligibility Schedule; and

4. The Subscriber provides CareFirst BlueChoice with proof of the Dependent child's medical or mental disability within 31 days after the Dependent child reaches the Limiting Age for Dependent Children or, if applicable, the Limiting Age for Student Dependents. CareFirst BlueChoice has the right to verify whether the child is and continues to qualify as a disabled Dependent child.

D. Dependents' coverage will automatically terminate if there is a change in their age, status or relationship to the Subscriber, such that they no longer meet the eligibility requirements of this Evidence of Coverage. Coverage of an ineligible Dependent will terminate as stated in the Eligibility Schedule.

This amendment is issued to be attached to 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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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 Physician's offices or in other CareFirst BlueChoice approved facilities	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 or Qualified Substance Abuse Treatment Facility, when admitted under the care of a Contracting Physician.	Coverage for the services listed below. The coverage is subject to the limitations, if any, described 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 is provided for Medically or Psychologically Necessary 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 Medically or Psychologically Necessary services for substance abuse and related mental health conditions include 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. Schedule of Benefits, Section 6, Mental Health and Substance Abuse Services, is deleted and replaced as follows:

Service	Limit on Benefits	Member Payment
SECTION 6 - MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Mental Health and Substance Abuse Services		
Office Visits	Number of visits not limited	No Copay or Coinsurance
Outpatient Facility	Number of visits not limited	No Copay or Coinsurance
Professional Services Provided at an Outpatient Facility	Number of visits not limited	No Copay or Coinsurance
Medication Management Office Visits	Number of visits not limited	No Copay or Coinsurance
Methadone Maintenance	Number of visits not limited	No Copay or Coinsurance
Inpatient Mental Health and Substance Abuse Services		
Inpatient Mental Health and Substance Abuse Facility Services	Number of days not limited	Benefits are available to the same extent as benefits provided for inpatient hospital services for treatment of other illnesses.
Inpatient Mental Health and Substance Abuse Professional Services	Number of visits not limited	Benefits are available to the same extent as benefits provided for inpatient medical or surgical care at an inpatient hospital for treatment of other illnesses.
Partial Hospitalization Program		
Partial Hospitalization Program Facility Services	Number of visits not limited.	No Copay or Coinsurance

Service	Limit on Benefits	Member Payment
Professional Services Provided in a Partial Hospitalization Program	Number of visits not limited.	No Copay 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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Chief Executive Officer and President

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Washington, DC 20065
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PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT

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

TABLE OF CONTENTS

The Evidence of Coverage is amended as follows:

A. Definitions

The following definitions have the following meaning in this amendment:

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

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) 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)).

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

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

C. Rescission

Any provision of the Evidence of Coverage that describes the right of CareFirst BlueChoice to rescind or void the Evidence of Coverage is amended to permit CareFirst BlueChoice to 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.

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

D. Preventive Services

In addition to any other preventive benefits provided in the Evidence of Coverage, CareFirst BlueChoice 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:

1. Evidenced-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, except that the current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member involved;

3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings 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

Any provision of the Evidence of Coverage that provides benefits with respect to services in an emergency department of a hospital is amended to provide Emergency Services:

1. Without the need for any prior authorization determination, even if the Emergency Services are provided by a Non-Participating Provider;

2. Without regard to whether the health care provider furnishing the Emergency Services is a participating provider with respect to the services; and

3. 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.

CareFirst BlueChoice, Inc.

Chester E. Burrell
Chief Executive Officer and President

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

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EXPANSION OF DEPENDENT COVERAGE AMENDMENT REVISED

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

TABLE OF CONTENTS

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;
6. Satisfaction of any combination of the above factors.

Nothing in this Amendment changes or amends the eligibility requirements for Primary Care Dependents 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, 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 Primary Care Dependent.

The eligibility requirements for Primary Care Dependents 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, 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.

The provisions relating to the Limiting Age and termination of coverage of Primary Care Dependents remain as stated in the Evidence of Coverage and in the Eligibility Schedule attached to 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 herein.

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Chester E. Burrell
Chief Executive Officer and President

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Washington, DC 20065
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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. Well child care visits for obesity evaluation and management;

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

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

4. Office visits for the treatment of childhood obesity; and

5. 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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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:

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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WOMEN'S PREVENTIVE HEALTH SERVICES AMENDMENT REVISED

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. Section 1.7 of the Description of Covered Services is deleted and replaced with the following:

1.7 Maternity Services.

A. Preventive Services

1. Routine outpatient obstetrical care of an uncomplicated pregnancy, including prenatal evaluation and management office visits and one post-partum office visit;

2. 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

3. 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.

4. Breastfeeding support, supplies and consultation.

5. 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.

B. Non-Preventive Services.

1. Outpatient obstetrical care and professional services for all prenatal, delivery and post-partum complications, including prenatal and post-partum office visits and Ancillary Services provided during those visits, including Medically Necessary laboratory tests and diagnostic services.

2. Birthing classes, one course per pregnancy, at a CareFirst BlueChoice approved facility.

3. Coverage for a hospital stay, including professional services for delivery.

4. Coverage for care rendered at a CareFirst BlueChoice approved licensed birthing center.

5. Non-preventive routine professional services rendered to the newborn during a covered hospitalization for delivery. Non-routine care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as a Member in the newborn's own right. Section 2.6 in the Evidence of Coverage describes the steps, if any, necessary to enroll a newborn Dependent Child.

6. Elective abortion.

C. Postpartum Home Visits. See Section 4.4C., Home Health Services.

III. 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.

IV. 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

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Chief Executive Officer and President

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Washington, DC 20065
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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.

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ALLOWED BENEFIT DEFINITION AMENDMENT

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

I. Evidence of Coverage, Section 1, Definition of Allowed Benefit, is deleted and replaced as follows:

Allowed Benefit means:

For a Contracting Physician or Contracting Provider, the Allowed Benefit for a Covered Service is the amount agreed upon between CareFirst BlueChoice and the Contracting Physician or 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.

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.

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 a Non-Contracting 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.

For a Covered Service rendered by a Non-Contracting Ambulance Service Provider, 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. It is the Member's responsibility to apply any CareFirst BlueChoice payments to the claim from the Non-Contracting ambulance service provider.

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

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GENDER REASSIGNMENT AMENDMENT

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

The Evidence of Coverage is amended as follows:

The Description of Covered Services is amended to delete:

Section 10.1 (L). 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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Chief Executive Officer and President

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COMPLEX CHRONIC OR HIGH RISK ACUTE DISEASE MANAGEMENT AMENDMENT

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

The Evidence of Coverage is amended as follows:

I. Evidence of Coverage, Definitions, is amended to add the following:

Care Plan means the plan of treatment created for a Qualified Individual under the Patient-Centered Medical Home Program (PCMH), through CareFirst BlueChoice Complex Case Management working in conjunction with the Qualified Individual's treating physician or nurse practitioner, or through a Chronic Care Coordination Program developed or implemented by a Chronic Care Coordinator.

Chronic Care Coordinator (CCC) means a registered nurse who develops and implements treatment plans for Qualified Individuals with chronic medical conditions in coordination with those treating physicians or nurse practitioners who do not participate in the CareFirst BlueChoice PCMH.

Complex Case Management (CCM) means the coordination of specialty services provided to a Qualified Individual with advanced or critical illnesses by Specialty Case Managers (SCM).

Designated Provider means a provider of a Chronic Care Coordination Program (CCP), Comprehensive Medication Review (CMR), Enhanced Monitoring Program (EMP), Expert Consultation Program (ECP), or Home-Based Services Program (HBS), outlined in this provision, who has been contracted by CareFirst BlueChoice to provide these services and who has agreed to participate in care coordination activities in cooperation with CareFirst BlueChoice for Qualified Individuals with complex chronic disease or high risk acute conditions.

Home-Based Care Management Plan means the designated medical and associated services prescribed for a Qualified Individual with a high risk of admission or readmission to a hospital.

Home Care Coordinator (HCC) means a registered nurse or other provider licensed or otherwise authorized by law to provide home care working in conjunction with the Qualified Individual's treating physician, nurse practitioner, SCM or LCC.

Local Care Coordinator (LCC) means a registered nurse who develops and implements Care Plans for Qualified Individuals with chronic medical conditions in coordination with those treating physicians or nurse practitioners who participate in the CareFirst BlueChoice PCMH program.

Qualified Individual, as used in this amendment, means a Member who:

A. Is accepted by CareFirst BlueChoice into one or more of the programs described in this amendment. CareFirst BlueChoice will consult with the treating

physician or nurse practitioner in order to determine whether the Member has a medical condition which meets the parameters for participation in one or more of the programs. CareFirst BlueChoice retains final authority to determine whether someone who meets the parameters for participation in a program will be accepted as a Qualified Individual.

B. Consents to participate and complies with all elements of the program(s) in which he/she qualifies.

C. Continues to meet the program criteria for participation and participates fully with any applicable plan of treatment. CareFirst BlueChoice and the Qualified Individual's treating physician or nurse practitioner will determine whether the Member is cooperating with the Home-Based Care Management Plan, Care Plan and/or plan of treatment.

Specialty Case Manager (SCM) means a registered nurse who works with a treating physician or nurse practitioner in order to coordinate the care needs of Qualified Individuals with complex medical conditions in accordance with the guiding principles of case management for complex specialty care including, but not limited to, oncology, hospice, rehabilitation, trauma, and high risk pregnancy.

II. Evidence of Coverage is amended to add the following:

A. The following benefits are available to Qualified Individuals to manage the care of complex chronic or high-risk acute diseases when provided by Designated Providers or through CareFirst BlueChoice:

1. Chronic Care Coordination Program (CCP). Benefits will be provided for a Designated Provider to work telephonically or otherwise with a chronically ill Qualified Individual and his/her treating physician or nurse practitioner to develop and implement a treatment plan.

2. Complex Case Management (CCM). Specialty Case Managers will initiate and perform CCM services, as deemed Medically Necessary by the Member's treating physician or nurse practitioner and CareFirst BlueChoice. Benefits include:

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

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

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

d) Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Individual's care with Specialty Case Managers;

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

f) Locating community resources, and other organizations/support services to supplement the Care Plan;

g) Implementation of a Care Plan in consultation with the Qualified Individual's treating physician or nurse practitioner.

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

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

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

6. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in the Home-Based Care Management Plan.

   a) The HBS coordinates care through an SCM or LCC for Qualified Individuals in a Care Plan who need considerable support at home, sometimes on a prolonged basis. Services provided may include a home health aide, psycho-social services and other behavioral health services as well as medication management and support in activities of daily living. If such services are needed, they are provided following a home-based assessment by an HCC and become part of the overall plan of care maintained by the LCC or SCM responsible for the Qualified Individual.

   b) The need for a Home-Based Care Management Plan is determined by the CareFirst BlueChoice SCM or LCC, working under the direction of the Qualified Individual's treating physician or nurse practitioner. Benefits will be provided for the HBS when the Qualified Individual is specifically referred to the HBS by an SCM or an LCC for full assessment and integrated home-based services pursuant to a Home-Based Care Management Plan. To be eligible for the HBS, the Qualified Individual must have a home-based assessment performed and completed by a Designated Provider.

      A person is deemed to be in a Home-Based Care Management Plan only after the home-based assessment is completed and the plan is subsequently approved by the Qualified Individual's treating physician or nurse practitioner and the CareFirst BlueChoice SCM or LCC.

   c) To maintain participation in the HBS, the Qualified Individual must:

      (1) Participate fully with the Care Plan and Home-Based Care Management Plan as determined by CareFirst BlueChoice and the Qualified Individual's treating physician or nurse practitioner; and,

      (2) Engage in regular communication with the HCC, LCC and/or SCM.

   d) Covered Services rendered to the Qualified Individual provided through or as a result of the Home-Based Care Management Plan will not count toward any visit limits stated in the Schedule of Benefits.

B. Member Cost-Sharing.

1. Any applicable Deductibles, Copayments and/or Coinsurance will be waived for services provided by a CCC, an HCC, an LCC, or a Care Coordination Team that are Designated Providers in connection with the service provided in Section II. when the Qualified Individual participates in one of the programs described herein. However, if the Qualified Individual's Evidence of Coverage is compatible with a federally-qualified Health Savings Account, then the Qualified Individual will be responsible for any associated costs for Covered Services provided when the Qualified Individual participates in one of these programs until the annual Deductible has been met.

2. Deductibles, Copayments and Coinsurance will only be waived for services rendered by Designated Providers. However, those services specifically outlined in a Qualified Individual's Home-Based Care Management Plan under Section II A (6) which are not rendered by a Designated Provider are eligible for the waiver.

C. Termination of the Chronic Care Coordination Program, Complex Case Management, Comprehensive Medication Review, Enhanced Monitoring Program, and Home-Based Services Program.

1. The Qualified Individual's participation in the CCP, CCM, CMR, EMP, or HBS will be terminated under the following circumstances:

   a) Upon completion of the stated goals of the CCP, CCM, CMR, EMP, or HBS as stated in the Care Plan or Home-Based Care Management Plan and confirmed by the Qualified Individual's treating physician or nurse practitioner, the applicable program will be terminated and the Qualified Individual will no longer be eligible for benefits under the terminated program.

   b) When the Qualified Individual fails to comply with the treatment plan of the CCP, CCM, CMR, or EMP or the Home-Based Care Management Plan of the HBS as determined by the CCC, CCM, HCC, LCC and/or SCM, as applicable, and the determination is approved by the Qualified Individual's treating physician or nurse practitioner.

   c) Termination of the coverage of the Qualified Individual under the Evidence of Coverage.

2. The Qualified Individual will be given written notice thirty (30) days in advance of the termination date. If termination of the CCP, CCM, CMR, EMP, or HBS is the result of the Qualified Individual's failure to comply with the CCP, CCM, CMR, EMP, or HBS, the Qualified Individual will be provided the opportunity to comply with the CCP, CCM, CMR, EMP, or HBS during the thirty (30) days prior to the termination of the applicable program(s).

   If after continued non-compliance during the thirty (30) day period and a consultation between the Qualified Individual's treating physician or nurse practitioner and the CCC, HCC, LCC and/or SCM, a determination is made that the Qualified Individual is not and will not be compliant with the applicable program(s), the Qualified Individual will receive a final written notice of termination of the applicable program(s).

3. Upon termination of the applicable program(s), the provisions stated in Section II B will be null and void and the Qualified Individual's cost-sharing responsibilities will be as stated in the Schedule of Benefits. This includes the Qualified Individual's cost-sharing responsibilities for services provided in the home under the EMP and HBS.

D. Exclusions and Limitations. Coverage will not be provided for the services listed in this amendment when rendered by non-Designated Providers unless the service is provided pursuant to a Home-Based Care Management Plan under Section II A (6) of 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.

CareFirst BlueChoice, Inc.

Chester E. Burrell
Chief Executive Officer and President

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

An independent licensee of the Blue Cross and Blue Shield Association

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:

I. Controlled Clinical Trials

A. The following definitions are added to Section 1, Definitions, of the Evidence of Coverage

Controlled Clinical Trial means a treatment that is:

A. Approved by an institutional review board;

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

C. Is approved by:

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

2. The Centers for Disease Control and Prevention.

3. The Agency for Health Care Research and Quality.

4. The Centers for Medicare & Medicaid Services.

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

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

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

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

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

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

9. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH.]

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 United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services, and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

B. Section 1.5 of the Description of Covered Services is deleted and replaced with the following:

1.5 Controlled Clinical Trials.

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

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

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

B. Coverage will be provided only if:

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

2. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for any other life-threatening condition;

3. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

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

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

6. Prior authorization has been obtained from CareFirst BlueChoice.

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

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
Chief Executive Officer and President

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

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

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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.

TABLE OF CONTENTS

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 calendar 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.

Chester E. Burrell
Chief Executive Officer and President

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

Allowed Benefit, as used in this rider, means:

The 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.

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 in the amount of the Allowed Benefit, minus any applicable Deductible, Copayment or Coinsurance. Members may be responsible for balances above the Allowed Benefit.

Benefit Period means the period of time during which covered Prescription Drug benefits are eligible for payment. The Benefit Period is on a Calendar year basis.

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 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.

Diabetic Supplies means all Medically Necessary and appropriate supplies prescribed by a health care provider for the treatment of diabetes.

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

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

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

Preferred 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.

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

Prescription Drug means: (i) a drug, biological or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;" (ii) drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such

treatment in standard reference compendia or in the standard medical literature; (iii) an Over-the-Counter medication or supply included on the Preferred Preventive Drug List; and (iv) any Diabetic Supplies.

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.

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 or an attached rider.

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. 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. 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.

4. A Member may select a Prescription Drug that is not included on the Preferred Drug List. However, if a Member opts for a Prescription Drug not included on the Preferred Drug List when a Prescription Drug on the Preferred Drug List is available, the Member will pay the higher non-Preferred Brand Name Drug Copayment or Coinsurance.

5. If a drug on the Preferred Drug List is determined to be inappropriate therapy for the medical condition of the Member, the Member will be allowed to obtain a specific, Medically Necessary non-Preferred Brand Name Drug for the non-Preferred Brand Name Drug Copayment or Coinsurance.

6. Providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Prescription Drug on the Prior Authorization List. A copy of the Prior Authorization List is available to the Member or Provider upon request.

7. **Timely Filing**: All claims submitted to CareFirst BlueChoice or its designee for Prescription Drugs purchased at a non-Contracting Pharmacy must be submitted within twelve (12) months after the date the Prescription Drug was dispensed. CareFirst BlueChoice or its designee will only consider claims beyond the twelve (12) month filing period if the Member became legally incapacitated prior to the end of the filing period.

8. Benefits include:
   a. Any contraceptive drug or device that is approved by the FDA for use by a woman as a contraceptive and is obtained under a prescription written by an authorized prescriber, including contraceptive drugs and devices on the Preferred Preventive Drug List. 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 to which this rider is attached.

   b. Human growth hormones.

   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 Preferred Preventive Drug List.

   d. Injectable medications that are self-administered and the prescribed syringes.

e. Standard covered items such as insulin, glucagon and anaphylaxis kits.

f. Fluoride products.

g. Diabetic Supplies: 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 to which this rider is attached.

C. MAIL ORDER PROGRAM

All Members have the option of ordering Prescription Drugs via mail order. Members ordering Prescription Drugs through the mail order program will be entitled to a thirty-four (34) day supply for non-Maintenance Drugs and a ninety (90) day supply for Maintenance Drugs. Members will be responsible for the Copayment or Coinsurance as outlined in Section D, Copayments and Coinsurance, below.

D. COPAYMENTS AND COINSURANCE

1. The Member must pay the Copayment or Coinsurance at the time that a prescription is filled by the Pharmacist.

2. For Prescription Drugs purchased in a Pharmacy or purchased through the mail order program, there is one Copayment due for each thirty-four (34) day supply. For Maintenance Drugs, a Member may receive up to a ninety (90) day supply provided the Member pays one Copayment for the first thirty-four (34) day supply and a second Copayment for a supply of thirty-five (35) days or more.

3. The Copayment is:
   a. Preferred Preventive Drug: $0 per prescription or refill.
   b. Generic Drug: $XX per prescription or refill.
   c. Preferred Brand Name Drug: $XX per prescription or refill.
   d. Non-Preferred Brand Name Drug: $XX per prescription or refill.

4. Contraceptive drugs and devices on the Preferred Preventive Drug List are not subject to a Copayment or Coinsurance. There is one Copayment due for a three (3) -month supply of oral contraceptive medications that are Brand Name Drugs that are not on the Preferred Preventive Drug List.

5. If the cost of the Prescription Drug is less than the Copayment, then the cost of the Prescription Drug will be payable by the Member at the time the prescription is filled.

6. Diabetic Supplies are not subject to any Copayment or Coinsurance.

7. Oral chemotherapy drugs are not subject to any Copayment or Coinsurance.

8. Preferred Preventive Drugs are not subject to any Copayment or Coinsurance.

E. DEDUCTIBLE

1. The Deductible is the dollar amount that a Member will need to pay towards Prescription Drugs during a Benefit Period before any benefit subject to the Deductible is provided for Prescription Drugs under this rider. The individual Member Benefit Period Deductible is $XX.

2. The maximum Deductible for Members covered under the same family membership is two times the individual Member Deductible amount. When this amount is reached

during the Benefit Period, no further Deductible amounts will be charged for Members under that family membership for the remainder of the Benefit Period.

Eligible expenses of all covered members can be combined to satisfy the family Deductible. An individual family member cannot contribute more than the individual Deductible toward meeting the family Deductible. Once the family Deductible is met in this manner, this will satisfy the Deductible for all covered family members.

3. The following covered Prescription Drugs are not subject to the Deductible:
   a. Diabetic Supplies;

   b. Organ and tissue transplant immunosuppressant Maintenance Drugs;

   c. Oral chemotherapy drugs;

   d. Colony stimulating factors; and

   e. Preferred Preventive Drugs.

F. EXCLUSIONS

Benefits will not be provided under this rider for:

1. Any devices, appliances, supplies, and equipment except as otherwise provided in Section B, above.

2. Routine immunizations and boosters such as immunizations for foreign travel, and for work or school related activities.

3. Prescription Drugs for cosmetic use.

4. Prescription Drugs administered by a physician or dispensed in a physician's office.

5. Drugs, drug therapies or devices that are considered Experimental/Investigational by CareFirst BlueChoice.

6. Except for items included on the Preferred 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.

7. 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 Preferred Preventive Drug List.

8. Infertility drugs and agents for use in connection with infertility services or treatments that are excluded from coverage under the Evidence of Coverage to which this rider is attached.

9. 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.

11. 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.

12. Prescription Drugs for weight loss.

13. Biologicals and allergy extracts.

14. 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
Chief Executive Officer and President